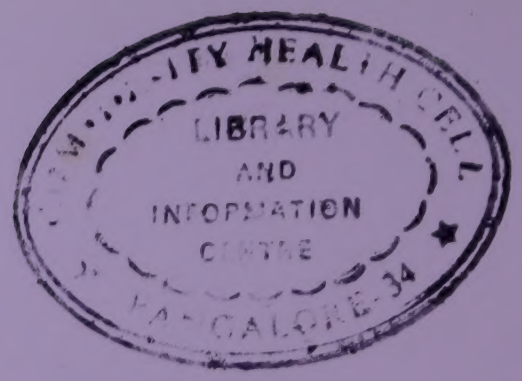
Book 01

PUBLIC HEALTH RESOURCE NETWORK

Introduction to Public Health Systems

NATIONAL RURAL HEALTH MISSION
राष्ट्रीय ग्रामीण स्वास्थ्य मिशन
(2005-2012)



Book 1

Public Health Resource Network

Introduction to Public Health Systems

Coordinating Agency

Public Health Resource Centre

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National Rural Health Mission

National Health Systems Resource Centre

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ICICI Centre for Child Health and Nutrition

National Institute of Health and Family Welfare

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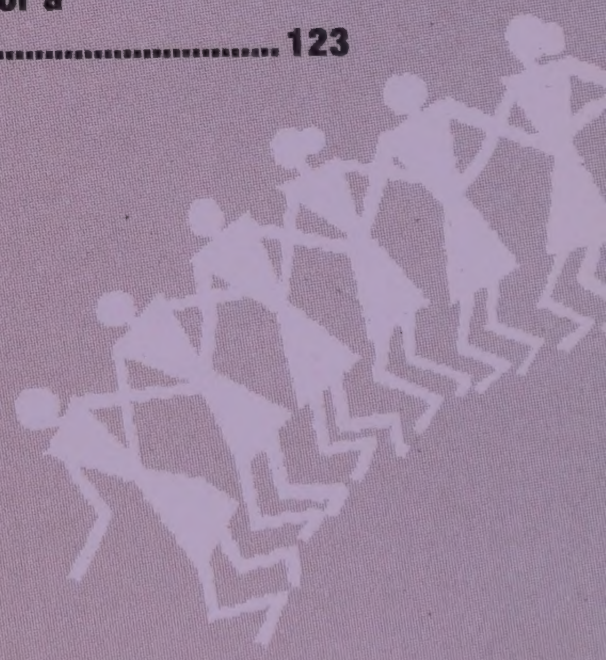


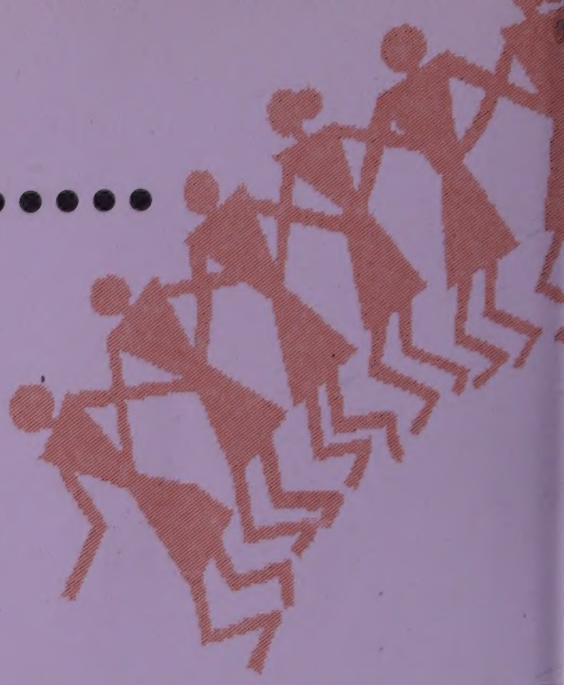
Preface

Public Health Resource Network

The National Rural Health Mission's vision of a national programme planned at the district level, and if possible at the village level, needs an exponential increase in capacities across the board. The NRHM has itself initiated many steps in this direction. However, given the vastness and diversity of the country and the rigidities of the planning and implementing structures, one needs to supplement the official national mission led process with many varied, creative and massive endeavors from state governments, health resource centers, different professional sections and different sections of civil society.

This initiative- called the Public Health Resource Network (PHRN) aims to provide support to public health practitioners working in the districts in all aspects of district health planning and public health management. The central element of this initiative is a capacity building effort structured as a distance learning programme. This distance learning programme is not a substitute to formal professional public health training and it does not carry with it any guarantees of increased employment or career options. It is meant to support individuals and organizations both within and outside the health department who are committed to working for a more equitable and effective public health system. This programme complements official training and education programmes through an open-ended, more informal and immediate reaching out with information, tools and a diversity of programme options and perspectives.

The course faculty and editors of the modules are drawn up exclusively from those who have been active in various states in providing support to governments and non governmental organizations in health and related sectors. This programme itself is being organized primarily by a number of agencies already providing resource support to states on different aspects of NRHM programmes.



A mission needs missionaries, and it needs them where the challenges are greatest- in the remote and most underdeveloped areas of the northern and eastern states, and indeed in all the under-served areas of all the states. A Health Mission needs these missionaries to also be professionals, where being a professional is not one more form of privilege- but a competence that anyone willing to put in the time and effort— and a little expense— can acquire!! Thus the contact programmes at district, regional and state level would evolve into mechanisms of sharing of resources, and building mutual solidarity amongst those who work for change, and of those who work in the health sector because they seek to work for the poor. The true test of the programme is thus not the number of certificates that we issue but the better quality of district plans, a higher motivation of district teams and eventually better health outcomes in the district. The immediate context is the National Rural Health Mission. But hopefully the voluntary network that emerges will contribute over the years to the evolution of a network of district and block level resource groups who provide technical support to all efforts at decentralized planning in governance and to all societal efforts towards an equitable and just society.

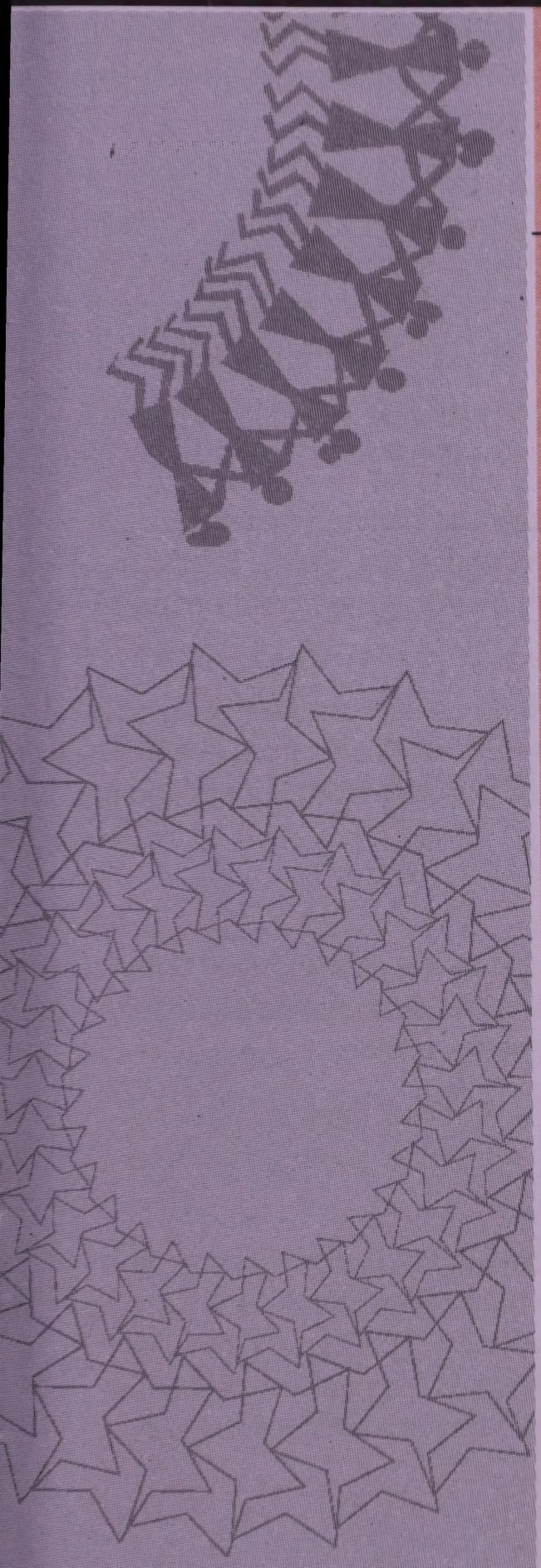
In this book, the first volume of the series, we discuss the evolution of the goals of the public health sector in India and the National rural Health Mission. We then also discuss the basic structure of the public health sector as it exists today. In particular we describe some fundamental design constraints of the key health care facilities which affect the implementation of all health programmes and discuss what can be done to improve these. This sets the stage for the discussion of other programmes in the subsequent volumes.

The plan is to constantly update and revise these books, based upon the experience of their use. We look forward not only to your learning from these books, but to your participation in the creation of future editions, and for this reason we look forward to your constant feedback.

Dr. T. Sundararaman
PHRN Programme Coordinator

Lesson ONE

The Goals of Public Health



In this lesson we shall discuss:

- The meaning of the term 'public health'
- The historical processes that led to the evolution of goals of public health in India
- The goals as defined in the Alma Ata Declaration and components of the term 'primary health care'
- The Millennium Development Goals
- The goals of public health with reference to addressing poverty

INTRODUCTION

When we discuss activities of the Government Departments of Health and Family Welfare, we usually discuss various **Health Programmes** or the functioning of various **Health Facilities**. All health programmes have specific objectives to reach towards which a number of activities are carried out. But health programmes are all part of a **Health Strategy**.

A **Health Strategy** is based on a health policy; it is a framework for the implementation of a health policy. A health strategy is an approach by which the goals that have been decided upon would be reached. A health strategy details not only health programmes, but also the legal framework that would be created, the institutions that would be set up, the material, human and financial resources that would be required, the way in which these would be obtained and the way that management and governance of the sector would be organised.

A **Health Policy** of the government is a statement about the government's goals for action in the health sector, as well as the broad approach by which these goals would be realised.

The **Goals of Public Health** and the strategy to attain these goals should be decided democratically. They should be based on technical information about which strategies work and which do not. In practice, democracy means that various groups with different degrees of influence over government shape an understanding of the goals and strategies.

In every module of the Public Health Resource Network course we shall be discussing health care strategies. In this opening chapter we shall discuss the goals of public health as distinct from strategies and we shall learn of some key historical landmarks that have contributed to our present understanding of the goals of health care.

An Explanation of the terms, Health System and Health Sector

By **Public Health System** do we mean the health care services provided by the government? That is what it generally comes to mean in the current Indian context. However it is best used to describe all the activities that the government undertakes to ensure the health of the people.

A related term is **Health Sector**. All processes and institutions that together contribute to the health of the nation are referred to as the **Health Sector**. This includes a Private Health Sector and a Public Health Sector.

However, even as regards the private sector, the government has a role to play. For example most of the doctors who work in the private sector have been educated in medical colleges run by the government. The government has the power to allow or ban various drugs from being sold, i.e., the government both offers subsidies and incentives to the private sector and has the power to regulate it. Such actions also have impact on the public health, and therefore we can talk of these roles as being part of the functions of the public health system.

THE BEGINNINGS - INDIA'S INDEPENDENCE AND THE BHORE COMMITTEE REPORT

The Bhore Committee

In 1945 when independence had become inevitable, the Government of India (then under British rule) set up a 26-member 'Health Survey and Development Committee' to recommend a health plan for independent India. This committee was chaired by Dr. Joseph Bhore, and its report submitted in 1946 came to be known as the Bhore Committee Report. Its recommendations were far-reaching, indeed revolutionary for its time and they anticipated by decades, the key understandings of the Alma Ata declaration by decades. Anger at the poor health status of people and the neglect of the health care services for the majority of the people, had contributed to the mobilisation that led to our independence. The Report was written in this context, with the recognition that independence was now inevitable and a new nation would require a long time vision on health. It was also a culmination of the way health care issues had got integrated with the other basic issues that led to the struggle for independence.

One of the first definitions of the goals of public health in India is in the foreword of the Bhore Committee Report of 1946, which is quoted below in the original unabridged form.

"*In this foreword an attempt is made to present, in a nutshell, the main principles underlying the Committee's proposals for future health development in the country. These are:*

1. *No individual should fail to secure adequate medical care because of inability to pay for it.*

2. *In view of the complexity of modern medical practice, the health services should provide, when fully developed, all the consultant, laboratory and institutional facilities necessary for proper diagnosis and treatment.*

3. *The health programme must, from the beginning, lay special emphasis on preventive work. The creation and maintenance of as healthy an environment as possible in the homes of the people as well as in all places where they congregate for work, amusement or recreation are essential. So long as environmental hygiene is neglected, so long as faulty modes of life of the individual and of the community remain uncorrected, so long as these and other factors weakening man's power of resistance and increasing his susceptibility to disease are allowed to operate unchecked, so long will our towns and villages continue to be factories for the supply of cases to our hospitals and dispensaries.*

4. *The need is urgent for providing as much medical relief and preventive health care as possible to the vast rural population of the country. The debt which India owes to the tiller of the soil is immense*

and although he pays the heaviest toll when famine and pestilence sweep through the land, the medical attention he receives is of the most meager description. The time has therefore come to redress the neglect which has hitherto been the lot of the rural areas.

5. *The health services should be placed as close to the people as possible in order to ensure the maximum benefit to the communities to be served. The unit of health administration should therefore be made as small as is compatible with practical considerations.*

6. *It is essential to secure the active cooperation of the people in the development of the health programme. The idea must be inculcated that ultimately, the health of the individual is his own responsibility and, in attempting to do so, the most effective means would seem to be to stimulate his health consciousness by providing health education on the widest possible basis as well as opportunities for his active participation in the local health programme.*

7. *We therefore consider it essential to the success of the scheme that its development should be entrusted to Ministers of Health who* enjoy the confidence of the people and are able to secure their cooperation."

This foreword summarises its long term and short term plans, and its suggestions towards developing a 'basic doctor", and calls for mobilising active support of the people for such a programme.

These ideas were new when they were proposed. The powerful opening line "no individual should fail to secure adequate medical care because of inability to pay for it" is still one of the most succinct and powerful articulations of health care as a basic human right. And in this vision of the Bhore Committee, the goals of health programmes were clearly seen as a set of desirable processes that should be guaranteed to the people.

> **No individual should fail to secure adequate medical care because of inability to pay for it.**

> **The health services should be placed as close to the people as possible in order to ensure the maximum benefit to the communities to be served.**

Subsequent committees and commissions were to refine and often redefine strategies in many ways. But largely the goals have remained unchanged. It is only with the Alma Ata Declaration and in the subsequent National Health Policy that these goals though essentially still the same- are further elaborated upon.

THE DECLARATION OF ALMA ATA

In 1978, the nations of the world came together in adopting a declaration, which is since known as the "Health for All by 2000AD" declaration. A set of historically defined processes led to the adoption of such a declaration at such a juncture. One of these was a set of technical inputs. There was now enough knowledge of diseases and their causation to assert that health was largely determined by a set of social and economic factors and that the vast majority of diseases could be prevented or treated by simple and affordable technologies. Also there was accumulating experience from all over the world that though social and economic development was the key, even within current socio-economic circumstances, a much higher level of health could be attained if the primary health care strategy was adopted. Simultaneously, both socialist countries and other social democratic countries had made universal health care central to government priorities, and the attainment of health had come to be seen as a basic requirement of modern civilised society. The process of de-colonisation was nearing completion. As the third world struggled to emerge as independent nations there was a consensus that attainment of health in these newly independent nations would be a priority for international cooperation. The Declaration of Alma Ata is considered the highest and best attainment of the World Health Organisation and one of the major achievements of the United Nations.

Declaration of Alma Ata
International Conference on Primary Health Care, Alma-Ata, September 6-12, 1978

The International Conference on Primary Health Care, meeting in Alma-Ata this twelfth day of September in the year Nineteen hundred and seventy-eight, expressing the need for urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all the people of the world, hereby makes the following Declaration:

I

The Conference strongly reaffirms that health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realisation requires the action of many other social and economic sectors in addition to the health sector.

II

The existing gross inequality in the health status of the people particularly between developed and developing countries as well as within countries is politically, socially and economically unacceptable and is, therefore, of common concern to all countries.

III

Economic and social development, based on a New International Economic Order, is of basic importance to the fullest attainment of health for all and to the reduction of the gap between the health status of the developing and developed countries. The promotion and protection of the health of the people is essential to sustained economic and social development and contributes to a better quality of life and to world peace.

IV

The people have the right and duty to participate individually and collectively in the planning and implementation of their health care.

V

Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures. A main social target of governments, international organisations and the whole world community in the coming decades should be the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. Primary health care is the key to attaining this target as part of development sin the spirit of social justice.

VI

Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.

VII

Primary health care:

reflects and evolves from the economic conditions and socio-cultural and political characteristics of the country and its communities and is based on the application of the relevant results of social, biomedical and health services research and public health experience;

addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly;

includes at least: education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunisation against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs;

involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors; and demands the coordinated efforts of all those sectors;

requires and promotes maximum community and individual self-reliance and participation in the planning, organisation, operation and control of primary health care, making fullest use of local, national and other available resources; and to this end develops through appropriate education the ability of communities to participate;

should be sustained by integrated, functional and mutually supportive referral systems, leading to the progressive improvement of comprehensive health care for all, and giving priority to those most in need;

relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community.

VIII

All governments should formulate national policies, strategies and plans of action to launch and sustain primary health care as part of a comprehensive national health system and in coordination with other sectors. To this end, it will be necessary to exercise political will, to mobilise the country's resources and to use available external resources rationally.

IX

All countries should cooperate in a spirit of partnership and service to ensure primary health care for all people since the attainment of health by people in any one country directly concerns and benefits every other country. In this context the joint WHO/UNICEF report on primary health care constitutes a solid basis for the further development and operation of primary health care throughout the world.

X

An acceptable level of health for all the people of the world by the year 2000 can be attained through a fuller and better use of the world's resources, a considerable part of which is now spent on armaments and military conflicts. A genuine policy of independence, peace, détente and disarmament could and should release additional resources that could well be devoted to peaceful aims and in particular to the acceleration of social and economic development of which primary health care, as an essential part, should be allotted its proper share.

The International Conference on Primary Health Care calls for urgent and effective national and international action to develop and implement primary health care throughout the world and particularly in developing countries in a spirit of technical cooperation and in keeping with a New International Economic Order. It urges governments, WHO and UNICEF, and other international organisations, as well as multilateral and bilateral agencies, non-governmental organisations, funding agencies, all health workers and the whole world community to support national and international commitment to primary health care and to channel increased technical and financial support to it, particularly in developing countries. The Conference calls on all the aforementioned to collaborate in introducing, developing and maintaining primary health care in accordance with the spirit and content of this Declaration.

Discussions about the Alma Ata Declaration

I. *What are the health goals enshrined in this declaration?*

In the accompanying box is a quick one-line indicative summary of each paragraph above. You may like to read back the declaration to understand what exactly it states about each of these goals.

Paragraph 1:	Defines health, Declares it as a fundamental, human right: makes attaining it an important social goal.
Paragraph 2:	Declares Health Equity as a goal.
Paragraph 3:	Declares social and economic development as necessary for attaining health and health as necessary for attaining social and economic development.
Paragraph 4:	People have a right – and duty - to participate in decision making on health; the central role of community participation.
Paragraph 5:	Declares health the responsibility of the government. Also defines primary health care as a key strategy to attaining health with social justice.
Paragraph 6/7:	Defines primary health care as a set of essential processes and lists its components. Note these two paragraph between them describe about 20 distinct processes as together constituting one category – a process called primary health care.
Paragraph 8:	Calls upon governments to formulate suitable policies and raise resources to achieving its goals.
Paragraph 9:	Calls for international cooperation to achieve these goals.
Paragraph 10:	States that the goal of health for all by the year 2000 is possible- If there is political will and if there is peace and disarmament to raise the resources needed to reach these goals.

It emerges from a reading of the document that the goals of health systems and even of primary health care is not a set of numbers representing a certain level of morbidity or mortality to be achieved . The goals are a set of processes.

However many countries find this declaration difficult to use as a policy instrument. For one, it does not set any targets of how much MMR, IMR to achieve. It does not even talk of what diseases to control.

Health planning has been always linked to achievement of such clear targets. Even when health plans are made in a district, the process usually starts with fixing one set of figures as goals. For example the RCH programme aims to reach a goal of IMR reduction to less than 30 per 1000 and MMR to less than 100 per 100000. Once this target is set, then the plan defines the processes by which these goals shall be attained.

II. On reading the Alma Ata declaration, it seems that the goals are certain key processes, and the figures of infant mortality rate and maternal mortality rate are at best merely indicators. The word target appears only once and then it refers to a process. Can you locate the word in the document?

So what is the goal and what is the indicator? What are the advantages and disadvantages at looking at an essential set of processes as the goal and at health statistics as indicators?
If we take achieving a level of IMR or MMR as the goal- then are attaining all the above processes essential to achieving this level of IMR or MMR? If on the other hand, attaining the above processes is seen as central, fixing goals of IMR and MMR would help in defining strategies to achieve this goal.

III. Does the Alma Ata declaration imply that all health care should be provided by the state?

Not necessarily. But it does, for example, require that people have a space to participate in decision making and it does require that the government be responsible to ensure universal access to these services. Examine the declaration to see what becomes the responsibility of the government, what is the role of people and of communities and what is the role of private sector and other allied sectors.

IV. In paragraph 1, the declaration states: *"...the attainment of the highest possible level of health is a most important world-wide social goal."*

And in paragraph 5, the declaration states: *"...the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. Primary health care is the key to attaining this target as part of development in the spirit of social justice.*

How do we understand these two slightly different goals? How do we understand primary health care in relation to all health care?

Soon after the Alma Ata declaration was adopted the Indian government adopted the National Health Policy in 1983 which enshrined most of the Alma Ata goals in the Indian context. The National Health Policy 1983 and the later National Health Policy 2002 are important reference documents for all health planners. These are discussed further in a later module (module 14).

MILLENNIUM DEVELOPMENT GOALS

In the year 2000, the nations of the world under the auspices of the United Nations adopted a millennium declaration which set a set of eight goals to be achieved by the year 2015, along with a set of 18 targets by which achievement of these goals would be quantified, along with a set of 24 indicators by which the achievement of these 18 targets would be measured. These Millennium Development Goals (MDGs) define much of health sector planning also – especially as much of the international agencies' assistance is provided with the specific aim of achieving these goals.

We give these goals with their targets below:

Goals and targets

GOAL	TARGET
Goal 1: Eradicate Extreme Hunger and Poverty	**Target 1.** Halve, between 1990 and 2015, the proportion of people whose income is less than $1 a day **Target 2.** Halve, between 1990 and 2015, the proportion of people who suffer from hunger
Goal 2: Achieve Universal Primary Education	**Target 3.** Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling
Goal 3: Promote Gender Equality and Empower Women	**Target 4.** Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015
Goal 4: Reduce Child Mortality	**Target 5.** Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate
Goal 5: Improve Maternal Health	**Target 6.** Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio
Goal 6: Combat HIV/AIDS, Malaria and other diseases	**Target 7.** Have halted by 2015 and begun to reverse the spread of HIV/AIDS **Target 8.** Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases

Goal 7: Ensure Environmental Sustainability	**Target 9.** Integrate the principles of sustainable development into country policies and programs and reverse the loss of environmental resources **Target 10.** Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation **Target 11.** Have achieved by 2020 a significant improvement in the lives of at least 100 million slum dwellers
Goal 8: Develop a Global Partnership for Development	**Target 12.** Develop further an open, rule-based, predictable, nondiscriminatory trading and financial system (includes a commitment to good governance, development, and poverty reduction both nationally and internationally) **Target 13.** Address the special needs of the Least Developed Countries (includes tariff- and quota-free access for Least Developed Countries, enhanced program of debt relief for heavily indebted poor countries [HIPCs] and cancellation of official bilateral debt, and more generous official development assistance for countries committed to poverty reduction) **Target 14.** Address the special needs of landlocked developing countries and small island developing states (through the Program of Action for the Sustainable Development of Small Island Developing States and 22nd General Assembly provisions) **Target 15.** Deal comprehensively with the debt problems of developing countries through national and international measures in order to make debt sustainable in the long term **Target 16.** In cooperation with developing countries, develop and implement strategies for decent and productive work for youth **Target 17.** In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries **Target 18.** In cooperation with the private sector, make available the benefits of new technologies, especially information and communications technologies

Discussion

These goals are accepted international goals of the health care system. In contrast to the Alma Ata declaration, this specifically names the lowering of under-5 child mortality rate (U5MR) and maternal mortality ratio (MMR) and the control of key diseases as its goals. It then not only sets targets but also lists indicators by which these shall be measured (not listed above).

These MDGs are really helpful for defining strategy and action plans as the strategic goals are clear. But there are a number of policy decisions required for any particular strategy to be put in place. The government strategy of public provision of health care services, and government's relationships with the private sector with respect to these goals needs to be defined for these goals to lead to a strategy. These policy aspects have not been spelt out. This can be an advantage – for it allows for policy formulation and defining the strategy at national and state government levels.

POVERTY REDUCTION AS PUBLIC HEALTH GOAL

The publication of the World Bank Annual Reports, especially the 1993 report, "Investing in Health" and subsequently the publication of the Report of the International Commission of Macro-economics and Health and the Report of the National Commission of Macro-Economics and Health have brought new dimensions of health goals into the debate.

It has been well recognised that there is a close relationship between poverty and health. It was always well recognised, even in the Bhore Committee Report and the Alma Ata declaration that investment in poverty elimination / reduction is essential for improving health which in turn would contribute to productivity and economic growth.

It is now further recognised that investment in health care is one form of transfer of resources to the poor- and therefore a form of poverty reduction. This is also old news- but its context is different. This is being currently articulated in a context of neo-liberalism –a belief that markets and free trade are to solve most problems including health and where the main role of government is to withdraw itself –at best regulating when there are conflicts and ensuring fair play. In such a context, transfers of resources in the form of food subsidies, trade subsidies, manufacturing subsidies or restraints on foreign investments are all forbidden, for it would interfere with a free play of market forces. However, investment in health as a form of transfer of resources to the poor has less opposition from the influential sections for many reasons as discussed further below.

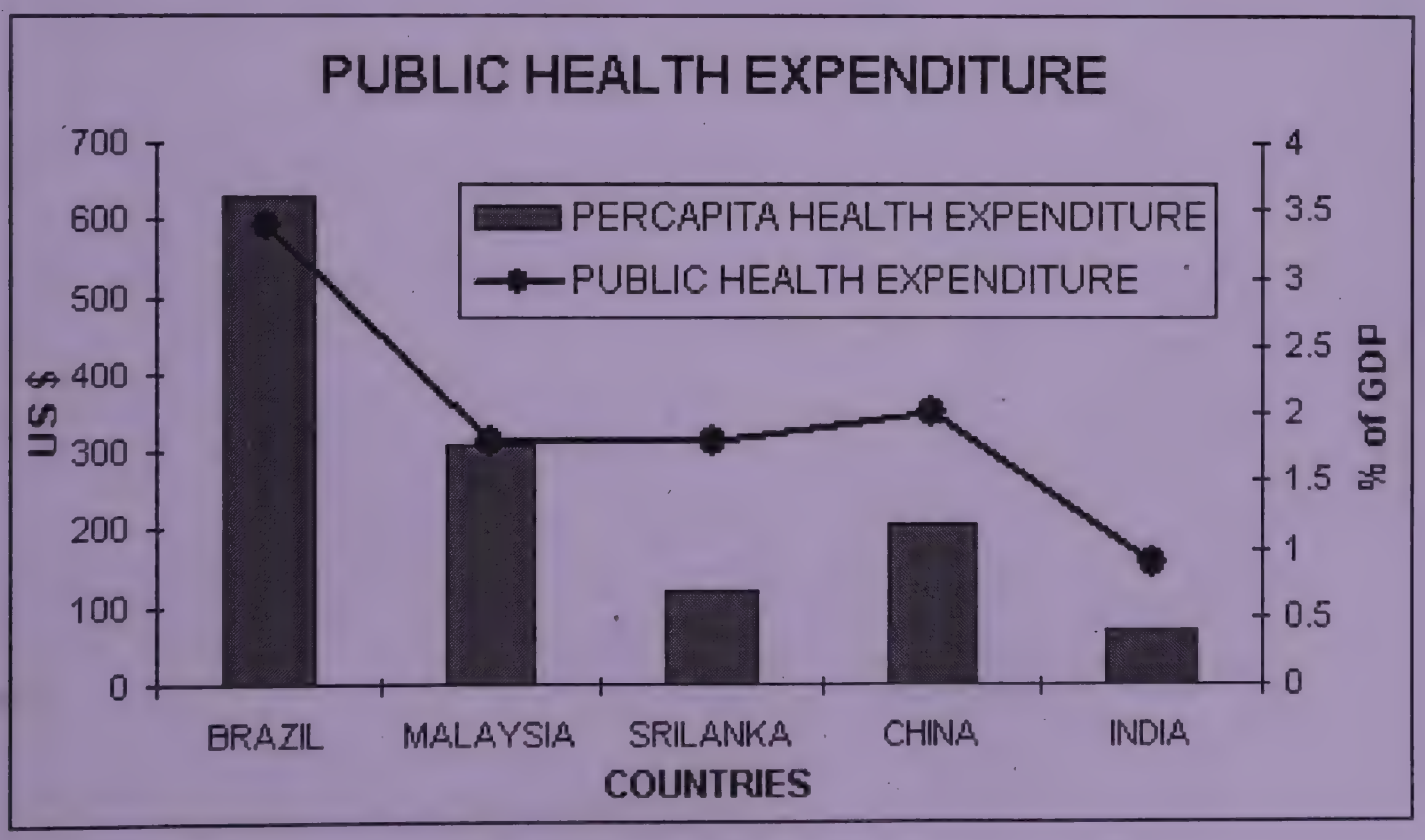
Tracing the historical impact of neo liberal ideology on health sector financing, there were many in the 1990s who believed and proposed that private health care provision would solve all problems. However, even some of those who believed that freeing markets was the key to economic development recognised that in health and especially in primary health care, there is a likelihood of market failure and government intervention is needed. Another argument was also that with free trade there would be economic set backs for the poor leading to worsening health status. Therefore a health system that could act as a "safety net" was required. Poor performance on health indicators like IMR and MMR were also perceived to be an embarrassment to governments in international circles and make it difficult for them to adopt and defend policies of privatisation and liberalisation.

However, a mere 'safety net' requirement from health care is quite different from a recognition of health care as a basic minimum human right and this fundamental conceptual discordance has continued to

plague health care policy up to the present date. Thus, this set of economic, ideologically driven considerations of the 1990s has influenced the goals of the health system considerably and this indeed marks a big step away from the thinking of the Alma Ata Declaration.

Meanwhile another set of arguments in favour of more public investment in health care have arisen in India. These have been captured in the Report of the National Commission on Macro-Economics and Health for India. From the mid-1990s onwards it has been brought to public attention that Indian public health expenditure is one of the lowest in the world. Total health expenditure in India is about 5-6% of the GDP which is about the same as the average for the world, but the per capita expenditure on health is lower than in most countries. Also, only about 18-22% of the total health expenditure in India is government health expenditure. This is one of the lowest in the world – only eight countries, including some countries with severe civil strife like Congo and Angola, spend less on health care. In contrast, in the developed industrialised nations of the world, about 75% of the total health expenditure is by the government. USA has the lowest expenditure amongst these industrialised nations but even here the government expenditure is twice as high as the Indian government's level of expenditure. If we exclude the USA, then the share of government expenditure in total health expenditure is almost 90% amongst the industrialised nations. For most countries in the world the figures are 40-70%.

Thus we see in the graph below that per capita expenditure on health care in only somewhere between 0.4 to 0.9% of the GDP whereas even in neighbouring Asian countries it is 2% of the GDP and in another third world country like Brazil it is as high as 3% of the GDP.



The implication of this is that in India most health care expenditure is out-of-pocket expenditure. This i turn implies that health care expenses are a major cause of indebtedness and poverty for rural household A single major health event can impoverish even a middle class family. Further, in about 20% of illnesses the poor cannot seek any medical care because of the prohibitive cost; even the free medical car available in the government system is too costly for people to access.

> **In India most health care expenditure is out-of-pocket expenditure. This in turn implies that health care expenses are a major cause of indebtedness and poverty for rural households.**

Given these considerations another set of goals now becomes central to the health system:

a) That there is financial protection for the people, especially the poor, from the high costs of healt care. This assumes special urgency because about 80% of all health care provision is by the private sector where costs are unregulated.
b) That the investment made by the government in health care be shown to act favourably on reducing poverty and in being accessed by the poor.
c) That the public share of total health expenditure increase significantly in line with internationa norms.

These set of goals have important consequences for strategy, because we are now explicitly stating neither health goals nor health indicators, but economic goals and indicators for the health system. These goals are clearly explicit in the Alma Ata declaration, but need to be read into the Millennium Declaration Nevertheless they are implicitly a part of any government's role in the health sector. These goals too would require specific strategies, and indicators to measure progress on this dimension.

All these considerations have influenced the formulation of goals of the National Rural Health Mission.

Review Questions

a) What are the health goals for India as emerges from a reading of the following sources
   a. Bhore Committee report: 1946
   b. Alma Ata Declaration: 1978
   c. Millenium Development Goals 2000

b) How does health sector policy contribute to exacerbating poverty? What does it mean to have a health sector policy that contributes to poverty reduction?

c) "Primary health care is the key strategy of achieving health for all." So what is primary health care?

d) What is the difference between goals, policies, strategies and indicators? Discuss.

Application Questions

1. What is the relevance of the Alma Ata Declaration in today's day and age?
2. How do economic policies affect health policy? Discuss.
3. What is the relationship between poverty and health?
4. Community Participation is one of the key goals in the Alma Ata Declaration. To quote. "The people have the right and duty to participate individually and collectively in the planning and implementation of their health care." But community participation could also be seen as means to achieve one of the Millennium Development Goals. So is community participation a goal or is it a strategy? What is your opinion on this?

Project Assignment

1. What are the health goals that are being set for district plans in your area? What would be the processes that would form part of your district health plan goals. What are the indicators that are forming part of the district plan's goals? In what way does the district plan look at the issue of investment in health contributing to poverty reduction?
2. Would you like to modify the current district plans goals after reading this lesson? What would be the modifications?

NOTES

Lesson TWO

National Rural Health Mission

In this lesson we shall discuss:

- The goals and objectives of NRHM
- The context and reasons for the creation of the NRHM
- What is new in the NRHM? How does it's approach seek to make a departure from the past
- The components of the NRHM
- The challenges for effective implementation of the programme
- The opportunities and threats before the programme

INTRODUCTION

The National Rural Health Mission was formally inaugurated by the Prime Minister on the April 12, 2005. This was preceded by wide ranging consultations with State governments, other ministries and with civil society organisations. There were some areas of wide agreement - especially in identifying the problems – but there were also significant areas of divergence. As the discussions proceeded, the ambit of the Mission expanded to not only include the whole of the health sector but a number of health related sectors also. The Mission documents also evolved with this change, and with it, even the vision, goals and approach have evolved considerably since the first drafts; indeed they continue to evolve.

The best way to view the National Rural Health Mission is of it as an overarching framework which sets the directions for the functioning of the entire health sector as well as health related sectors. It is certainly not to be viewed as a project or as another scheme but an effort to reform, expand and accelerate the entire range of health related activities of the government.

GOALS OF THE NATIONAL RURAL HEALTH MISSION

Vision

- Provide effective healthcare to rural population throughout the country with special focus on 18 states, which have weak public health indicators and/or weak infrastructure,
- Increase public spending on health from 0.9% GDP to 2-3% of GDP, with improved arrangement for community financing and risk pooling,
- Undertake architectural correction of the health system to enable it to effectively handle increased allocations and promote policies that strengthen public health management and service delivery in the country,
- Revitalise local health traditions and mainstream AYUSH into the public health system,
- Effectively integrate of health concerns, through decentralised management at district level, with determinants of health like sanitation and hygiene, nutrition, safe drinking water, gender and social concerns.
- Address inter-state and inter-district disparities.
- Set time bound goals and report publicly on progress.
- Improve access of rural people, especially poor women and children to equitable, affordable, accountable and effective primary health care.

OBJECTIVES OF NRHM

- Reduction in child and maternal mortality
- Universal access to public services for food and nutrition, sanitation and hygiene, and universal access to public health care services with emphasis on services addressing women's and children's health and universal immunisation
- Prevention and control of communicable and non-communicable diseases, including locally endemic diseases
- Access to integrated comprehensive primary health care
- Population stabilisation, gender and demographic balance
- Revitalisation of local health traditions & mainstream AYUSH
- Promotion of healthy life styles.

DISCUSSION

Three points in the above list are relatively new or being re-discovered and they are elaborated upon below:

1. Vision statement: "Increasing public spending on health from 0.9% of GDP to 2-3% of GDP"

This was one of the most important goals in the first drafts of the Mission documents. It is also an important commitment of the National Health Policy. Now it is a key element elevated from a goal to a vision. Why?

Increasing public spending, i.e. spending by the government, is critical because international comparisons show that there is a close relationship between public spending on health and health outcomes. The higher the public spending, the more likely it is that the health status of the population is better. This is in contrast to total expenditure on health where the correlation is not as obvious. Higher expenditures do not necessarily co-relate to better health outcomes. Total health expenditure in India is 5-6% of GDP which is comparable to the situation in most countries- though it is higher in the industrialised nations. But public spending on health care in India is at 0.9% of the GDP, and this is one of the lowest in the world

Most countries of the world have a higher percentage of public expenditure on health as compared to total expenditure on health. In India, public spending is 22% of total health expenditure. In the industrialised nations of the world where we believe the economy is almost completely privatized, the public spending is 75% of total health expenditure. If we exclude the USA, the public spending level of the industrialized nations reaches almost 90%. Even in the United States over 44% of the expenditure on health is by public spending. In most of the third world countries it ranges from 40 to 60 %. In the entire world there are only about 8 countries, most of them war-torn, which have less than the Indian level of public spending on health.

Why is it so low in India? This will have to be discussed in later modules – but one can think of possible answers. Indeed even now it is quite a challenge to achieve higher public spending.

This is because the health departments are unable to spend the money allotted to them. There are structural constraints to the health departments being able to absorb more funds even though they need it!!! That is the context in which the next vision statement needs to be read

2. **Vision statement: "Undertake architectural correction of the health system to enable it to effectively handle increased allocations and promote policies that strengthen public health management and service delivery in the country."**

What does this notion of architectural correction mean? What are the current design problems that require redesigning by an architect? These are issues that we will discuss in different modules as we go along. But it is worth making a list of what you feel could be the reasons why the government is unable to effectively handle increased allocations.

3. **Vision statement: "Effective integration of health concerns through decentralised management at district level, with determinants of health like sanitation and hygiene, nutrition, safe drinking water, gender and social concerns."**

Objectives:

- "Universal access to public services for food and nutrition, sanitation and hygiene and universal access to public health care services with emphasis on services addressing women's and children's health and universal immunisation."
- "Access to comprehensive primary health care."

The Health for All by 2000 document– i.e. the Alma Ata declaration – inspires such a statement and this is a re-discovery for this document has not been quoted much in recent times. What are the implications of this for planning the strategy of the National Rural Health Mission?

Expected Outcomes

One form of expressing objectives is also to state in measurable terms what outcomes would be achieved.

The expected outcomes from the Mission as reflected in statistical data

- IMR reduced to 30/1000 live births by 2012.
- Maternal Mortality reduced to 100/100,000 live births by 2012.
- TFR reduced to 2.1 by 2012.

- Malaria Mortality Reduction Rate - 50% up to 2010, additional 10% by 2012.
- Kala Azar Mortality Reduction Rate - 100% by 2010 and sustaining elimination until 2012.
- Filaria/Microfilaria Reduction Rate - 70% by 2010, 80% by 2012 and elimination by 2015.
- Dengue Mortality Reduction Rate - 50% by 2010 and sustaining at that level until 2012.
- Cataract operations-increasing to 46 lakhs until 2012.
- Leprosy Prevalence Rate –reduce from 1.8 per 10,000 in 2005 to less that 1 per 10,000 thereafter.
- Tuberculosis DOTS series - maintain 85% cure rate through entire Mission Period and also sustain planned case detection rate.
- Upgrading all Community Health Centres to Indian Public Health Standards.
- Increase utilisation of First Referral units from bed occupancy by referred cases of less than 20% to over 75%.
- Engaging 4,00,000 female Accredited Social Health Activists (ASHAs).

The expected outcomes at community level

- Availability of trained community level worker at village level, with a drug kit for common ailments.
- Health Day at Anganwadi level on a fixed day/month for provision of immunisation, ante/post natal check ups and services related to mother and child health care, including nutrition.
- Availability of generic drugs for common ailments at sub Centre and Hospital level.
- Access to good hospital care through assured availability of doctors, drugs and quality services at PHC/CHC level and assured referral-transport-communication systems to reach these facilities in time.
- Improved access to universal immunisation through induction of Auto Disabled Syringes, alternate vaccine delivery and improved mobilisation services under the programme.
- Improved facilities for institutional deliveries through provision of referral transport, escort and improved hospital care subsidised under the Janani Surakshya Yojana (JSY) for the below poverty line families.
- Availability of assured health care at reduced financial risk through pilots of Community Health Insurance under the Mission.
- Availability of safe drinking water.
- Provision of household toilets.
- Improved outreach services to medically under-served remote areas through mobile medical units.
- Increase awareness about preventive health including nutrition

WHAT IS THE POLITICAL CONTEXT OF THESE CHANGES?

Many major health initiatives from the time of the Bhore Committee Report onwards have been related to changes in political understanding and political will. In a democracy like ours political will is essential to

drive change. However, political will is not a fixed or predetermined commodity. It is something that can be *built up* and *built upon*, and one needs to understand its correlation with change. It has always played a major part in shaping public health programmes but most textbooks of public health would prefer not to deal with it at all.

The NRHM has also been similarly shaped by the political context of its creation. The National Rural Health Mission (NRHM) was first announced in September 2004. The Mission was projected as a major undertaking by the newly elected UPA government to honour its commitments under the Common Minimum Programme. The UPA represented a broad centre-left coalition of political parties, which depended for its survival on consensus with even relatively minor parties, many of whom had never been in governance together. To ensure that the political mandate on which they were joining or supporting the coalition was explicit they adopted the Common Minimum Programme (CMP). The political commitment to rural health and access to primary health care that the CMP articulated was itself a change of policy. It marked a departure from an earlier political projection where the most advertised achievements had been the sanctioning of six AIIMS-type institutions, the promotion of medical tourism in India and the introduction of telemedicine – which were all highlighted as features of an 'India Shining.' There was a political need for the new government to distinguish itself from the earlier policies by explicitly announcing programmes that were seen to be pro-poor.

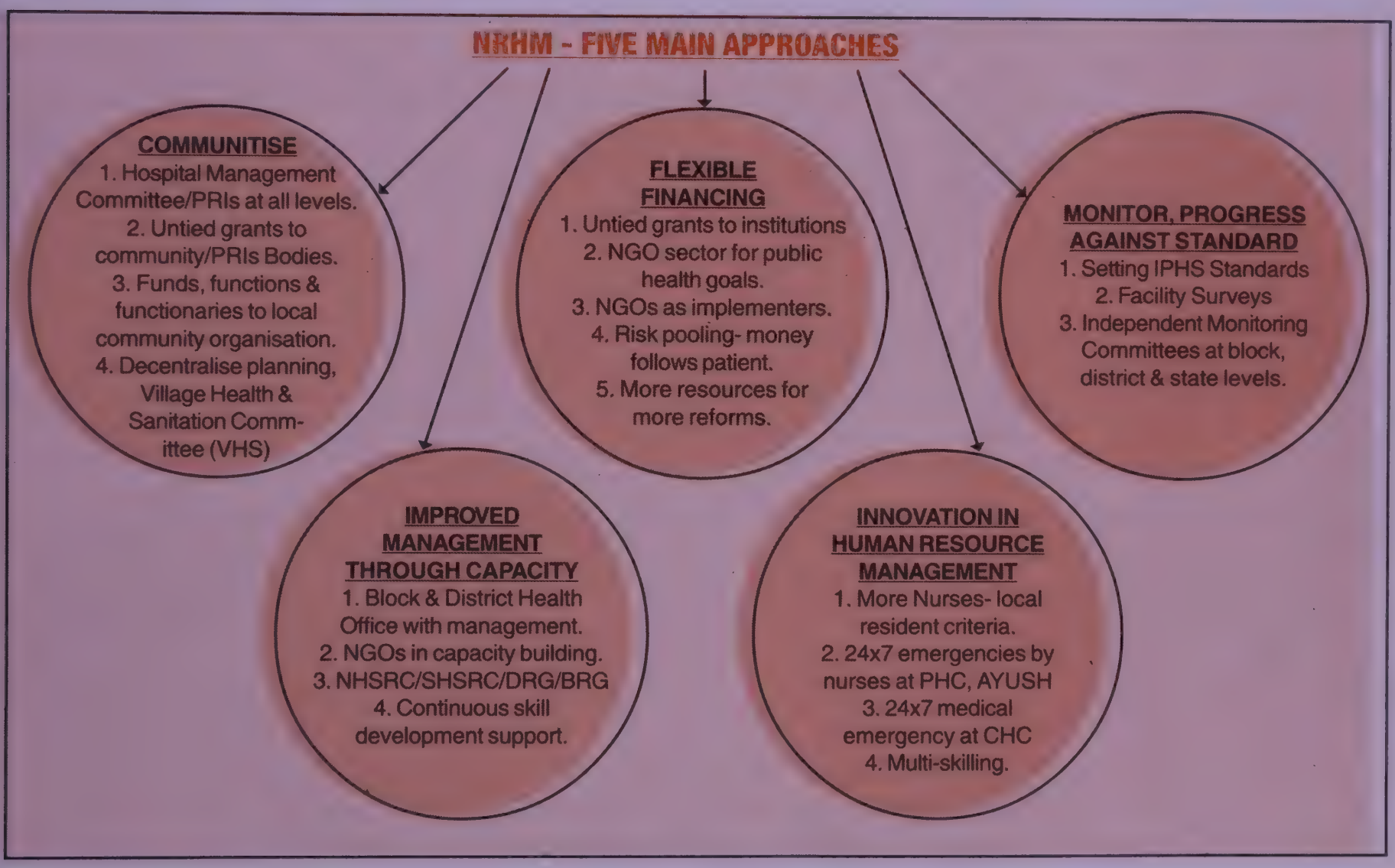
As a follow up to the adoption of the CMP, a National Advisory Committee (NAC), had been created as a civil society organisation to guide and ensure the implementation of the CMP, with the President of the ruling party as the Chairperson of the Committee. A number of key NAC members put forth papers which contributed to initiating and defining the Mission and its goals.

The announcement of the NRHM drew, almost immediately, a number of stakeholders into defining it. One influence was the already highly evolved "RCH-II programme", a programme that had been carefully negotiated through with a consortium of all donors- World Bank, USAID, EU, DFID, WHO and UNICEF. The immediate challenge with the Ministry of Health & Family Welfare was to synergise the political initiative of the NRHM with its plans for the RCH-II calendar. Another initiative of the earlier government, the National Commission on Macroeconomics and Health, had significant contributions to offer. Academicians like the group from the Jawaharlal Nehru University also made their contributions. Different Secretaries of related Departments and State Departments of Health were others and even the Prime Minister's Office actively participated and contributed to shaping the Mission. Relatively new and active entrants into the discussions and debates were a number of NGOs, many of them were loosely grouped into a network known as the People's Health Movement (or Jan Swasthya Abhiyan). This network was by no means a homogenous entity and most of its leading lights, doyens of the public health field over three decades or more, were to submit a profusion of independent comments and contributions that had some common threads running through them, but were otherwise quite diverse. The network itself also submitted a well worked out consensus document detailing its position on various aspects of the NRHM.[3]

The question remained: What was it that was new in the NRHM? There was a wide range of conclusions that the participants reached. Some stated that there was no change at all. Others were concerned that the existing trends to privatise would get exacerbated. Yet others were more hopeful that there was a significant change at the level of policy, though it would be a challenge to get the implementation going.

The NRHM itself had to define what was new in its approach or strategy through which it would reach these goals.

FIVE APPROACHES OF NRHM: THE NRHM STRATEGY



Components of NRHM: The Main Activities

The main activities or components of the National Rural Health Mission as listed in the Mission Document of April 2005:

a. ASHA programme: (community health volunteers)
b. Strengthening the Sub Centre
c. Strengthening the Primary Health Centre
d. Strengthening Community Health Centre or FRUs
e. Integrated District Health Planning
f. Converging sanitation and hygiene under NRHM
g. Strengthening Disease Control programmes
h. Public Private Partnership for Public Health Goals including regulation of Private Sector
i. New Health Financing Mechanisms
j. Reorienting Health /Medical Education to support rural health issues

FRAMEWORK OF IMPLEMENTATION: REFORMS AND ARCHITECTURAL CORRECTION

In terms of architectural correction for defining the framework of implementation, the NRHM has stated the following:[1]

A. Action at the Central level

The NRHM specifically commits to making more resources available, to developing regulations and setting standards, to issuing guidelines and implementation frameworks, to development of partnership with non governmental stakeholders, and effective monitoring of performance and support for capacity development at all levels.

B. Leadership of States

The NRHM is an effort to strengthen the hands of States to carry out the required reforms and provide them with additional resources to enable them to meet the diverse health needs of their citizens. In turn, States would commit to decentralised planning and implementation arrangements to ensure that need-based and community-owned District Health Action Plans become the basis for interventions in the health sector. At the same time, the States are also required to take action to increase their expenditure on health sector by at least 10% every year over the Mission period. The States would also be expected to adhere to mutually-agreed milestones which would be reflected in a MOU to be signed with each State.

In turn, States would commit to decentralised planning and implementation arrangements to ensure that need-based and community-owned District Health Action Plans become the basis for interventions in the health sector.

C. Institutionalising community-led action for health

The NRHM calls for Panchayati Raj Institutions (PRIs), from the village to the district level, to be given ownership of the public health delivery system in their respective jurisdiction. This includes legislative action, efforts at capacity building and the provision of untied grants to implement locally made plans. Other vibrant community organisations and women's groups will also be associated in communitisation of health care.

Monitoring committees would be formed at various levels, with participation of PRI representatives, user groups and CBO / NGO representatives and periodic *Jan Sunwai* or *Jan Samvad* at various levels are other proposed measures.

The NRHM calls for Panchayati Raj Institutions (PRIs), from the village to the district level, to be given ownership of the public health delivery system in their respective jurisdiction.

D. Promoting Equity

Empowering those who are vulnerable through health education, giving priority to areas/hamlets/ households inhabited by the more vulnerable groups, running fully functional facilities, exemption for below-poverty line families from all charges, ensuring access, risk pooling, human resource development / capacity building, recruiting volunteers from amongst them, are all important strategies under the Mission

E. Promoting Preventive Health

The NRHM will increase the range and depth of programmes on Health Education / IEC activities which are an integral part of activities under the Mission at every level and which are expected to correct the curative bias of current health services.

F. Dealing with Chronic Diseases

India has one of the highest disease burdens in the world. The number of deaths due to chronic diseases is very high. It is proposed to integrate these with the regular health care programmes at all levels.

G. Reducing child and maternal mortality rates and reducing fertility rates – population stabilisation through quality services

NRHM provides a thrust for reduction of child and maternal mortality and reduce the fertility rates. The approach to population stabilisation is to provide quality heath services in remote rural areas along with a wide range of contraceptive choices to meet the unmet demand for these services. The strategy also is to promote male participation in family planning. Reduction in IMR/MMR will also be closely monitored through social audit, which is being introduced at the Panchayat level.

H. Management of NRHM activities at State / District / Sub District level and Block Level Pooling

The success of the decentralisation experiment will require that management capacities be built at each level. Management structures at all levels will be accountable to the PRIs, the State Level Health Mission and the National Level Mission/Steering Group. Block Level Pooling will be one of the priority activities under the NRHM. Keeping in view the time line needed to make all facilities fully functional, specialists working in PHCs will be re-located to CHCs to facilitate their early conversion to FRUs. Outreach programmes will be organised with "block pooled" CHCs as the nodal point.

I. Human resources for rural areas

Improvement in the health outcomes in the rural areas is directly related to the availability of the trained human resources. The Mission aims to increase this availability through provision of more than 4 lakh trained women as ASHAs / Community Health Workers (resident of the same village/hamlet for which they are appointed as ASHA). The Mission also seeks to provide minimum two Auxiliary Nurse Mid-wives (ANMs) (against one at present) at each Sub Health Centre (SHC) to be fully supported by the Government of India, to provide three Staff Nurses to ensure round the clock services in every PHC and integrate AYUSH by co-location at PHC or by new contractual appointment. The Mission seeks to bring the CHCs on a par with the Indian Public Health Standards (IPHS) to provide round the clock hospital-like services. As far as (wo)manpower is concerned, it would be achieved through provision of seven specialists as against four at present and nine staff nurses in every CHC (against seven at present). A separate AYUSH setup would be provided in each CHC/PHC.

Given the current problems of availability of both medical as well as paramedical staff in rural areas, the NRHM seeks to try a range of innovations and experiments to improve the situation. These include

incentives, compulsory rural posting , a fair, transparent transfer policy, improved career progression for Medical / Para Medical staff, skill upgradation and multi-skilling of the existing staff including Medical Officers, strengthening of nursing / ANM training schools and colleges to produce more paramedical staff, and partnership with non governmental stakeholders to widen the pool of institutions.

J. National and State level Resource Centres for capacity development

The implementation teams of the NRHM, particularly at district and state levels, will require development of specific skills. Institutions like National and State Institutes for Health and Family Welfare which were primarily envisaged as research and training organisations may not fit the bill for this purpose. The National Health System Resource Centre (NHSRC), could be developed for this purpose. It is proposed to have one NHSRC at the national level and another Regional Centre for the North Eastern region. State level Resource Centres will be provided for EAG states on a priority to enable innovations and to develop new technical skills in the health system. In addition to the above, a number of existing reputed organisations with a national caliber may be strengthened and facilitated to mentor state health resource centres and district resource groups so that they are able to support the state level planning efforts. (Chhattisgarh has a State Health Resource Centre which acts as an additional capacity to the Department of Health and Family Welfare of the Government of Chhattisgarh and has an MOU with the State RCH Society.)

The NRHM will also require a comprehensive plan for training at all levels. A comprehensive training policy is being developed to provide support for capacity building at all levels including PRIs and the community.

K. Drug supply and logistics management

Timely supply of drugs of good quality which involves procurement as well as logistics management is of critical importance in any health system. The current system in most states leaves much to be desired. There are a few notable exceptions like Tamil Nadu which has developed a very effective system of supplies and logistics. The NRHM supports state-led initiatives for capacity building and setting up of State Procurement Systems and Distribution Networks for improved supplies and distribution. In order to take informed procurement decisions, market intelligence is of utmost importance. In the long run, NRHM would like the procurement to take place in a decentralised manner at the district level.

L. Monitoring and Accountability Framework

The NRHM proposes an intensive accountability framework through a three pronged process of community based monitoring, external surveys and stringent internal monitoring. Facility and Household Survey, NFHS-II, RHS (2002) would act as the baseline for the mission against which the progress would be measured.

M. Convergence within the Health Department

The intention of convergence within the Health Department is also to reorganise human resources in a more effective and efficient way under the umbrella of the common District Health Society. Such integration within the Health Department would make available more human resources with the same financial allocations. It would also promote more effective interventions for health care.

N. Convergence with other departments

The success of convergent action would depend on the quality of the district planning process. The District Health Action Plans will reflect integrated action on all issues that determine good health – drinking water, sanitation, women's empowerment, adolescent health, education, female literacy, early child development, nutrition, gender and social equality. At the time of the appraisal of the District Health Plan, care will be taken to ensure that the entire range of wider determinants of health have been considered in the approach to convergent action.

O. Role of Non Governmental Organisations

Non-Governmental Organisations are critical for the success of NRHM. The Mission has already established partnerships with NGOs for establishing the rights of households to health care. Besides advocacy, NGOs will be involved in building capacity at all levels, monitoring and evaluation of the health sector, delivery of health services, developing innovative approaches to health care delivery for marginalised sections or in underserved areas and aspects, working together with community organisations and PRIs, and contributing to monitoring the right to health care and service guarantees from the public health institutions. The NRHM will make an effort to support and facilitate action by NGOs which will contribute to the sustainability of innovations and people's participation in health. A Mentoring Group has already been set up at the national level for ASHAs to facilitate the role of NGOs. Grants-in-aid systems for NGOs will be established at the District, State and National levels to ensure their full participation in the Mission.

P. Risk pooling and the poor

There is an urgent need to set up effective risk pool systems in order to reduce the distress to poor households from illness related costs. Innovative and flexible insurance products need to be developed and marketed that provide risk pooling and remove financial barriers to government and non governmental facilities. Involvement of NGOs and community based organisations as insurance providers and as third party administrators can help to generate more confidence that the risk pooling arrangement is pro people and in the interests of poor households.

While setting up of effective health insurance systems is clearly a very important mission goal, it is realised that the introduction of such a system without the back up of a strong preventive health system and curative public health infrastructure will not be cost effective. Such a venture would only end up subsidising private hospitals and lead to escalation of demand for high cost curative health care. The first priority of the Mission is therefore to put the enabling public health infrastructure in place.

It is envisaged that the hospital care system would progressively move towards a fully funded universal social health insurance scheme.

Q. Reforms in Medical/Nursing Education

The medical / paramedical education system would require a new orientation to achieve these objectives. This would include

a. promoting new medical colleges in deficient states.
b. correct undue emphasis on specialisation and tertiary care with more emphasis on preventive aspects of health and primary health care.
c. equipping medical colleges and other suitable tertiary care centres with a variety of special short term courses to train medical officers to handle a large number of essential specialist functions in those states where the number of medical colleges and postgraduate courses are below recommended norms.
d. Short term programmes are needed to upgrade skills of nurses and ANMs to that of nurse-practitioners for those centres/regions which potentially have adequate nurses, but a chronic shortage of doctors over at least two decades.
e. Strengthening of Nursing Colleges wherever required, as the demand for ANMs and Staff Nurses and their development is likely to increase significantly.
f. Special attention would be given to setting up ANM training centres in tribal blocks which are currently underserved by paramedics by linking up with higher secondary schools and existing nursing institutions.
g. Improving skills of Registered Medical Practitioners would also be introduced.
h. Universal continuing medical education programmes which are flexible and non-threatening to the medical community, keeps them abreast of medical advances, and provides access to unbiased medical knowledge, and opportunity to refresh and upgrade existing knowledge and skills.

R. Pro-people partnerships with the non-governmental sector

The non-governmental sector accounts for nearly 4/5th of health expenditure in India. In the absence of an effective Public Health System, many households have to seek health care during distress from the non-governmental sector.. The NRHM attempts the following:

a. provide people friendly regulation framework that promotes ethical practice in the non-governmental sector,
b. encourage non-governmental health providers to provide quality services in rural areas to meet the shortage of health facilities there,
c. provide for training and up-gradation of skills for non-governmental providers wherever such efforts are likely to improve quality of services for the poor,
d. make arrangements for demand side financing to meet health care needs of poor people in areas where the Public Health System is not effective,
e. encourage not-for-profit centres which are identified as setting an example of pro-poor, dedicated community service, as role models, benchmarks, sites of community-centreed research and training to strengthen the public health system and improve the regulatory frameworks for the non governmental sector as a whole.

CHALLENGES BEFORE THE NATIONAL RURAL HEALTH MISSION

Getting a good policy in place is a big help – but implementing it is a challenge. Most of the key strategies and components of the NRHM programme have been tried before and they have not worked as expected. Decentralisation, ensuring accountability, district level planning , community health workers, private sector partnerships – many of these have been tried and to some extent given up because of poor results. However it is also true that most of these principles are of a fundamental nature and irrespective of past experience need to be aimed for again and again and again. Indeed we need to learn from past experience so that we have a better shot at it this time.

There is also much in-built resistance to change in such a system. Understanding its roots, being able to negotiate past it, build institutional structures that can work with it and yet be able to continue to promote changes is one of the challenges of the Mission.

All the five approaches outlined require a tremendous increase in capacities- not only within the health system, but also in community and civil society representatives. Since the Mission is time bound and requirements for capacity building are large and time consuming, a number of large parallel initiatives and institutional frameworks would be needed.

A very strong pro-poor political agenda would have to be maintained if this programme has to get the political and administrative support it needs.

Review Questions

1. What are the main goals of the NRHM?
2. What is the context of the launching of NRHM? What forces are described as shaping it?
3. Why are the goals of increased public spending and of architectural correction made key goals and later elevated into visions of the NRHM?
4. Compare the goals of the NRHM with the goals of the Health for All Document.
5. Compare the goals of the NRHM with the goals of the Millenium Declaration.
6. What are the key strategies or approaches that the NRHM has outlined?
7. What are the areas that the NRHM sets out as areas of reform or architectural correction?
8. What are the key challenges in achieving these goals.

Application Questions

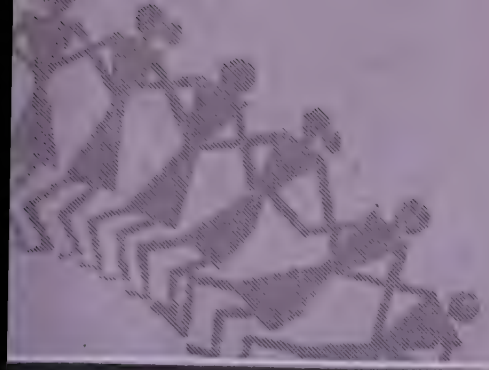
- Consider the goals of the NRHM in relation to your district? What would be the baselines both as regarding processes and as regarding outcomes in your district?

Project Assignment

- Collect the baseline figures on each of the goals as are available from different sources for the district. If a district plan has been made this should be having these baselines.

1. This has been abridged from the Framework of Implementation of the NRHM which is a document approved by the Cabinet as one of the central documents of the Mission. (The full document is available in the website of the NRHM. Copies can also be obtained from us or downloaded from the PHRN website)

NOTES



Lesson THREE

Structure of the Public Health System: An Overview

In this lesson we shall discuss:

- The structure of public health care services in India
- The norms for the institutions which are part of these services
- The services that should be delivered at each level

(Persons working in the health sector may just skip this lesson, as this brief description is well known to them. This section is to ensure that the terms we are using and the basic categories within which we will be discussing the health system are defined and understood by all course participants.
Do note however the way we use the terms PHC and CHC.)

STRUCTURE OF THE PUBLIC HEALTH SYSTEM

The health system has been conventionally viewed as a pyramid. At the bottom is the Health Sub- centre (HSC), above that, the Primary Health Centre (PHC), above which is the Community Health Centre (CHC) and then the District Hospital and then the teaching hospital.

Below is a brief over view of each of these facilities.

The Health Sub-centre

The Health Sub-centre is the facility closest to where people live and work. The norms for a Health Sub-centre are:

1. One Health Sub-centre for a population of 5000 in all areas except in tribal, hilly or desert areas where the norm is one Sub-centre per population of 3000 population.
2. An area of roughly 5000 population (3000 in rural areas) to be covered by a sub- centre is often referred to as a **section**..
3. In many states the entire area has been divided into sections and since the number of sections is more than the number of Sub-centres, a Sub-centre may have to look after part or whole of an adjoining section which is without a Sub-centre. In other places, the gap between Sub-centres sanctioned and those needed is covered by increasing population per Sub-centre and not by carving out sections which await sanction of the Sub-centres. It should also be noted that decadal population increase increases population per Sub-centre or per section.

Staff

A health Sub-centre has two workers – a male worker and a female worker. They are called Multi-purpose Worker (Male) – MPW(M) and Multi-purpose Worker (Female) - MPW (F)..The MPW (M) is often simply referred to as the MPW and the MPW (F) is often referred to as the ANM, i.e. auxiliary nurse midwife.

In most states the post of the MPW (M) lies empty and there have been no recruitments over years. The male worker is paid for by the state, while the female worker is paid for by the central government.

The functions of the Sub-centre may be listed as given in the box below:

Multi-Purpose Worker (Female) – MPW (F)

RCH Programme

1. **Antenatal:**
   1. Registration of ante-natal cases
   2. Immunisation of ANC i.e. Tetanus Toxoid and distribution of iron and folic acid and encouragement to take it
   3. At least 3 checkups during antenatal period
   4. Blood test for haemoglobin and urine test for all ANC cases.
   5. Early detection and referrals of complications in pregnancies
   6. Ability to perform normal delivery in sub centre/home and supervision of normal labour conducted by trained birth attendant.
   7. Scheduling of regular antenatal clinics and offer of help to Lady Health Visitor (LHV). *LHV is also referred to as Health Assistant (Female) or Health Supervisor (Female) and refers to the supervisor cadre of the MPW (F)*
   8. Dietary advice to antenatal patients

2. **Intrapartum:**
   1. Conduct normal delivery in sub centre/home and supervise normal delivery conducted by trained birth attendants at home

3. ***Post partum care :***
   1. Follow up of post partum patients and provide them health education
   2. Refer post partum cases with complication

4. **Child care / Care of the new born:**
   1. Weigh the neonate
   2. Refer the low birth weight babies to doctor
   3. Encourage early exclusive breast feeding , especially of colostrum
   4. encourage to start weaning after six months
   5. Train mother on how to take care if the baby has diarrhea
   6. Immunise i.e.with BCG, Polio, DPT, Measles, DT as also give vitamin A syrup at 9 months and every subsequent six months till three years of age.

Care In Diarrhea

1. Provide ORS & refer when needed .
2. Teach mother how to take care of the baby when baby has diarrhea & how to use ORS / other home based fluids

Respiratory Tract Infections

1. To treat babies with minor or upper respiratory tract infection & refer to Medical Officer in severe infection.

Malnutrition

1. To measure grade of malnutrition in children under 5 and provide iron and folic acid tabs.
2. To refer the children with grade III & IV malnutrition to MO
3. To provide Vitamin A syrup to all children
4. Educate and create awareness in community on how to provide proper nutritious food to children.

Family Welfare

1. Refer MTP cases & follow-up such cases
2. Provide information to community regarding MTP
3. Advise on spacing to eligible couples, encourage them to use temporary contraceptives like condoms, oral pills and CuT
4. Help to make arrangements to get tubectomy & vasectomy done for eligible couples & follow up of such cases.

Miscellaneous

1. Detect cases of RTI among woman & refer them to PHC
2. Detect cases STD among women & refer them to PHC

Training

1. Help/Assist the medical officer & LHV in conducting training for trained birth attendant .
2. Arrange meetings and provide information on various health issues to the women health groups.

Administration

1. Maintain records of all the activities in the subcentres
2. Provide reports on regular schedule and keep record of work
3. Register marriage, pregnancy, birth & death.
4. Maintain general records

First Aid

1. Provide first aid in accident & in cases of medical and surgical emergency
2. Refer all complicated cases to MO

Group Task

1. To participate in monthly meetings and work in coordination with MPW male / TBA and LHV
2. To meet the LHV twice a week for obtaining guidance to attend the camps and special campaigns
3. To remain in regular contact with the adolescent girls & provide them sex education & family health
4. To conduct school Health Programmes

MULTI-PURPOSE WORKER (MALE) – MPW (M)

The male worker has all the work listed above for the MPW (F) as well. However, the notification talks of *assisting* the ANM. The tasks include:

Immunisation

1. To fix the day, time and place for immunisation.
2. To keep in touch with the members / representatives of the community to provide help in immunisation .
3. To take help of TBA, Anganwadi worker and members of the health community to mobilise children for immunisation.
4. To obtain vaccines from sector supervisor on stipulated date and time
5. To make sure that all the children under-5 are immunised
6. To make sure that children under-1 are immunised with BCG, DPT, oral polio, measles and also get vitamin A in proper dose .
7. To ensure TT immunisation at the age of 10 and 16.
8. To help supervisor (male) in immunisation of school children.
9. To help the MO and supervisor in special immunisation campaigns.
10. To conduct a follow up on second day of immunisation and inform and refer to MO in cases with complications
11. To help ANM in giving injection TT to antenatal care patients.

In addition, the MPW (M)'s job list has the following:

Malaria

1. To make slides for malarial parasite (MP) for all cases with fever and give them presumptive treatment.
2. To provide specific treatment to all MP-positive cases.
3. To educate the community on prevention of malaria.

School Health

1. To help the MO in conducting a health camp at school.
2. To give health education to school children regarding maintenance of personal cleanliness
3. To help the health supervisor in immunisation of school children.

Infectious disease

1. To continually collect information regarding cases of gastroenteritis, jaundice, measles, colitis, diarrhea or any other infectious disease, and on getting cases in any village, inform health supervisor and take measures to prevent spread.
2. To provide health education regarding prevention of infectious diseases.
3. To disinfect well-water and other sources.
4. To provide information to the community on how to purify water; regular surveillance of the areas where people get drinking water from river, pond and streams; distribute and teach how to use chlorine tabs.
5. To distribute ORS packets and teach community members how to use them.

THE PRIMARY HEALTH CENTRE

In some states this is still referred to as additional PHC or mini-PHC- in contrast to the main PHC or block PHC which is now to be referred to as the CHC.

The Primary Health Centre is the primary unit of our public health delivery system and therefore merits a close scrutiny. The norms laid down for a Primary Health Centre are as stated below:

1. One primary health centre for a population of 30,000 in plains region and 20,000 in hilly, tribal and difficult areas.
2. An area of roughly 30,000 population (20,000 in rural areas) to be covered by a PHC is known as a sector.
3. In many states the numbers of sectors are more than the number of PHCs, and new PHCs have to be created to service that 'sector without PHC'. Currently the sector would be covered by a neighboring PHC which would thus be covering a population of about 60,000.

STANDARD STAFF STRENGTH OF A NEW PRIMARY HEALTH CENTRE

Medical Officer	1
Pharmacist /compounder	1
Staff Nurse	1
Multipurpose Health Worker (Female)	1
Health Assistant (Female)	1
Health Assistant (Male)	1
Health Educator	1
Laboratory Technician	1
Dressor	1
Driver	1
Class IV	4

The staff strength of all PHCs is sanctioned at the state level and this standard pattern shown above is not present in any state. Each state has some variant of this pattern.

Also note that in many states, the two health assistants would be sanctioned and posted per sector (a unit of 30,000 population), while the rest of the staff in this list above would be posted per PHC. This is important to note because often the number of PHCs sanctioned are less than the number of sectors sanctioned. Health assistants would be sanctioned according to the number of sectors or in proportion to number of Sub-centres whereas staff like compounders or medical officers would be sanctioned according to the number of PHCs.

Functions of the PHC

The functions of a PHC are, broadly:

- To supervise and provide guidance to the Sub-centres and their staff in implementing RCH programmes and other national programmes,
- To provide primary level curative cares services including referral services to the Sub-centres along with basic laboratory services. A minimal in-patient service of 2-6 beds had also been envisaged, at least for institutional deliveries.

For a detailed statement of the norms of service delivery laid down by the IPHS standards see annexure 1

THE COMMUNITY HEALTH CENTRE

In many states this is referred to as the Block PHC or the Main PHC or just as PHC. This can be confusing because when someone, for instance, in Bihar is referring to a PHC, he is actually referring to what is now to be called a CHC.

Community Health Centres (CHCs) are usually located at the Block Headquarters. They are meant to cater to the needs of about 1.2 lakhs population, and in tribal areas to about 80,000 population. By norms, a CHC is to provide referral back up to about 4 Primary Health Centres and about 20 Health Sub-centres.

CHCs are 30-bed hospitals, with laboratory facilities, X-Ray and ECG machines, labour rooms and an operation theater. CHCs are designed to be the First Referral Units for the cases referred from the primary health centres. They are also meant to provide specialist care in medicine, obstetrics and gynecology, surgery and pediatrics.

In practice since many of these CHCs were earlier PHCs, though they have been renamed CHCs, their bed strength and facilities have not yet been upgraded to what is required of a CHC. Effectively they remian PHCs.

DISTRICT HOSPITALS

The specifications of district hospitals vary widely. Since they are completely funded by the states, there has been no central guideline in active use, until the formulation of IPHS standards in 2006. Most officers would accept a 100-bed hospital as a minimum, though much larger hospitals can also be seen in some states.

In addition to the four specialties in adequate number – surgery, gynecology, medicine and pediatrics – the district hospital also has anesthesia, orthopedics, and eye, ear, nose and throat specialists. It should have a biochemist, a pathologist, a microbiologist and a radiologist. It should also have a skin specialist and mental health specialists.

The diagnostics (laboratory and radiology services) need to be sufficiently advanced for it to act as a referral centre. The district hospital usually has a kitchen to serve food to patients and a laundry service.

The services the district hospitals offer vary, but essentially all services that do not need sub-specialists like neurosurgeons or cardio surgeons or cardiologists, need to be available here.

Sub-District Hospital: Civil Hospital/Taluka Hospital/Sub-Divisional Hospital/Area Hospital

Between the CHC at the block and the district hospital, there exist a fair number of hospitals that may go by one of a variety of names – some of which are indicated above. Thus they can have anything from 10 beds to 100 beds – often they have about 50 beds.

These hospitals have been left over from a previous organisation of facilities when the concept of a CHC had not been proposed. At that time, every block had a block-level PHC and there was another hospital needed between the PHC and the district hospital, the taluka hospital or civil hospital, since the districts were very large. When districts were carved into smaller districts, most of these taluka hospitals became district hospitals- but some have got left behind.

For practical purposes it would be enough to raise these hospitals to CHC standards so that we have a functional FRU in the vicinity. More important if there is both a block PHC and a civil hospital in the same block it is enough to raise one of these to CHC standards. Quite often the block PHC is raised to CHC standards in addition to the civil hospital thus creating excess capacity – but poorly functional due to manpower gaps.

One reason why these hospitals get less attention for reform is because they are not under the control of the district Chief Medical Officer but under the Civil Surgeon who is of equal rank to the Chief Medical Officer and reports directly to the State Director. Since district planning is under the Chief Medical Officer, the civil hospital may get left out of the planning.

The Tertiary Health care System

These generally refer to the medical college hospitals. In common usage, district hospitals are often referred to as tertiary care hospitals. This would be a wrong usage since they are, as a rule largely secondary level hospitals. A tertiary care hospital must be able to provide the entire range of specialist services – covering at least surgery, medicine, pediatrics, obstetrics and gynecology, dermatology, orthopedics, ENT, ophthalmology, psychiatry, anesthesia, microbiology, biochemistry, pharmacology, forensic medicine, pathology including hematology, radiology and radiotherapy and preventive and social medicine.

Where a hospital manages only one specialty, for example, an eye hospital or a cancer hospital, this too is part of the tertiary health care system.

For the most part however, tertiary care hospitals are synonymous with the medical college hospital. Most tertiary care hospitals would necessarily engage in research. Often cases are referred to tertiary care hospitals, which do not conform to common local patterns of disease. These uncommon variations of common diseases or instances of rare diseases can be identified and understood only if research capability is in place. In addition to this higher degree of skills a higher level of diagnostics and access to knowledge is also required.

There are many functions that a tertiary health care system is expected to perform for primary health care systems. Some of these are listed below:

1. **Train medical manpower** for the primary and secondary health care system: doctors, specialists, nurses, laboratory technicians etc.
2. **Upgrade skills** of existing staff, especially medical and nursing staff in the public health system – and even for the private health system through continuing medical education programmes and skill upgradation programmes.
3. **Act as a research site:** This contributes by providing guidance about local health problems and providing regular communication to health care providers about changing disease patterns. For example, health care providers would need information about antibiotic sensitivity/drug resistance pattern. For instance, at a given time one type of bacteria would be the commonest cause of pneumonia and it would be most sensitive to one particular drug which may be cheaper. A report on this to all the doctors in the district would help them change their treatment since it is impossible to determine the causative organism or its antibiotic profile or the drug resistance pattern at the PHC level. There are many such areas of information which tertiary health care systems need to provide to the primary and secondary levels of care.
4. **Act as referral site:** The tertiary health facility receives and manages cases from secondary and primary systems which cannot be handled at that level. It should also providw feed back to the refering centres so that they learn tertiary care centres also refer cases that once diagnosed at the tertiary level can be followed up at the local level itself, to save costs. Thus about 90% of epilepsy patients can easily be treated and cured by weekly or monthly basis at the local PHC by an MBBS doctor, provided the specialist in a tertiary care centre examines the patient once, perhaps does a CT scan, rules out more serious causes that would need treatment only in about 10% of cases, and instructs the PHC doctor if any special care is needed in management. But if the patient has to go to the specialist every week, it is costly for both the patient and the health system. The tertiary care facility becomes overcrowded while the primary health system remains under-utilised and the doctor working there gets frustrated or just apathetic. With such a referral in place, when a patient reaches a PHC he is not just going to a one-doctor facility but entering an entire structured district health system with all its facilities. Unfortunately such referral feedback systems are nowhere in place- except perhaps a very limited extent for tuberculosis.

THE ASSOCIATED DEPARTMENTS

Health Services and Medical Education: Two or more departments

Usually Health Sub-centres, Primary Health Centres, CHCs and District Hospitals together constitute one department and the medical colleges are part of anoher separate department. In some states the CHCs and District Hospitals also become part of a separate department. All of the above departments come either under the Director of Health Services and the Director of Medical Education.

In addition to these two departments or sections, two other important departments need to be noted. One is the Department of AYUSH- ayurveda, yoga, unani, siddha and homeopathy- earlier known as the Department of Indian/Indigenous Medical Systems.

We will be discussing this is a separate lesson.

The other is the Office of the Food and Drug Controller. This office is the key to ensuring that pharmacies are licensed, drugs sold are of quality and drug control laws are observed, that food adulteration does not occur etc. It is a very rudimentary and a limited expression of the regulatory role of the government which, as we shall see, also gets implemented in a very limited manner.

Review Questions

1. What is the staffing pattern of a health Sub-centre?
2. What is the work expected of a female or male multi-purpose health worker?
3. What are the norms of facility to population for tribal areas?
4. What role does the tertiary health facility play in primary health care?

Project Assignments

a. How many health Sub-centres are needed in your district to meet the norms? How many are currently sanctioned and established (irrespective of degree of functionality). List this block-wise. Note that it is not enough to divide the population by 5000/or 3000. You must leave out urban areas in the numerator. But differentiate between urban area which will have an urban health programme and large villages or towns which are not large enough and therefore still in the category of rural health service.

b. What is the sanctioned staff set-up (also referred to as administrative set-up) in your state for the PHC? What is the sanctioned staff set up per sector?

c. How many PHCs are needed in your district to meet the norms? How many are currently sanctioned and established (irrespective of degree of functionality).

d. What is the sanctioned staff set-up (also referred to as administrative set-up) in your state for the CHC? Does it differ from CHC to CHC, and if so, find out why this has happened?

e. Is there a sub-district hospital in your district? In which block? Is there also a CHC or district hospital in the same block?

f. Using the facility survey forms given in the annexure, do a survey of one or two Sub-centres, one or two PHCs and a CHC. If there are other participants in the course you may like to share out and do different facilities so that together you have a larger sample. One can copy from one other, but only if you were present and part of the team that did the survey for some of the facilities.

NOTES

Lesson FOUR

Strengthening the Sub-Centre

In this lesson we shall discuss:

- The problems of access to sub-centres and what can be done to ameliorate them
- The hard gaps of infrastructure, equipment and supplies and how we would address these
- The issues concerning job description and suggestions regarding this
- The issues concerning workforce skills and motivation which constrain their outputs
- The justification of the sub-centre and the possibility of alternatives

SUB-CENTRE FUNCTIONING

The ANM (or MPW (F)) represents one of the most functional and successful of the various components of the entire health system - and since she is the key player in most preventive care and her location is the Sub-centre, we talk about the Sub-centre both as a facility and the ANM inter-changeably.

What is the current degree of ANM/Sub-centre effectiveness in RCH?

The latest round of NFHS (2005-06) is indicative of the situation regarding some key indicators of service delivery.

Table 4.1: Service coverage situation – 2005-06

Item	Percentage
Percent of mothers who receive antenatal check up from any professional at any time	77.0
Iron and folic acid tablets for at least 90 days during last pregnancy	22.3
Assisted at birth – By a skilled person ANM/LHV/Nurse/Doctor	48.3
Institutional Births	40.7
Women who have heard of AIDS	57.0
Percent of children who receive –	
• All vaccinations	43.5
• BCG	78.2
• Polio	78.2
• DPT-3 doses	55.3
• Measles	58.8
Percent of children with diarrhea in the past two weeks who received ORS	26.2
Percent of children with ARI in the past two weeks taken to a health facility or provider	64.2

Source: NFHS III (2005-06)

All of these indicators point to gaps in service delivery by Sub-centres. These gaps, in both access to and quality of services, exist as a result of failure to create or locate sub-centers as per population norms, problems due to geography, gaps in infrastructure, and most critically human resource related issues (the job description, the level of workforce skills and motivation levels). We discuss these issues in details below.

I. Access to Sub-centres

a. There may be fewer Sub-centres sanctioned than are required as per population norms.

b. The Sub-centres are not less in number but they are unevenly distributed. In some places there are more sub-centres than needed by population norms whereas in others there are less.

c. The Sub-centres are in large villages or towns- and one ANM finds it difficult to cater to a population of over 5000. Sometimes the population can be as high as ten thousand or 15,000. This leads to a poor Sub-centre to population ratio though in fact the villages are all adequately covered geographically. When more Sub-centres are sanctioned they are allocated amongst the already covered villages on the understanding that the large village already has its Sub-centre.

d. The Sub-centre to population ratio is adequate- but it is located poorly inside the village. It may be at one edge of the section outside the main village area – often some distance away in an isolated spot or often near a cremation ground.

e. It may be central to the section (cluster of villages) geographically but the road connections are poor and not aligned to economic activity and social life. Geographical distance is not the only- much less, most important consideration. People would find it easier to combine a market visit, with a visit to the sub-center.

II. Gaps regarding infrastructure and equipment and supplies

a. In many states, especially in the poor performing states, only one fourth to one third of Sub-centres have a proper government building conforming to minimum requirements. Most of them operate from rented buildings and quite a few share space in other government buildings – like Panchayat bhavans, anganwadi centres (whose infrastructure situation is, as a rule, worse off).

b. Even where the sub-centres are in government buildings, at least one third of them may be in poor condition and many of them require maintenance.

c. Those in rented buildings have seldom enough space for the minimum functions of the Sub-centre. Often the ANM stays in the same rented space where she has to see patients. In effect, she cannot examine patients, much less assist in child birth, in the same room that serves as her residence. If the rental is paid by the government, the government has some claim in asking her to take a larger house on rent where at least one or two rooms can be used for service delivery. But often she is paying for the rent herself, or at least the main part of the rent – in which case she feels justified in not seeing patients in that space.

d. The equipment is deficient in one or more essentials. Usually it is a case of the equipment having got used up or being in a state of disrepair and needing repair or replacement.

e. Furniture may be inadequate. Storage space for drugs and equipment and other supplies may also be inadequate.

f. The drugs and supplies come in the form of drug kits - Drug Kit A and Drug Kit B. These are sent by the Government of India. Some states supply drugs other than these kits – in others the drugs get restricted to the kits. This list of drugs given in these kits (see box below) is quite insufficient to manage the usual problems that the ANM needs to manage. Further, these kits come at different times and there are often ma ny long time-gaps when there are no supplies.

Drug Kit A- for each Sub-center		
S. No.	**Drugs/ Consumable**	**QUANTITY**
1	Oral Rehydration Solution	150
2	Tablet IFA (Large)	15000
3	Tablet IFA (Small)	13000
4	Vitamin A solution (100 bottles)	6
5	Tablet cotrimoxazole (100+20 MG)	1000

Drug Kit B- for each Sub-center		
S. No.	**Drugs/ Consumable**	**QUANTITY**
1	Tab. Methylergometrine Meleate (0125 mg)	500
2	Tab . Paracetamol (500 mg)	500
3	Inj. Methylergometrine Maleate ampule	10
4	Tab. Mebandazole	300
5	Tab. Dicyclomine HCL. (10 mg.)	250
6	Chloramphenicol Eye Ointment	500
7	Ointment Poviodine Iodine 5% tube	5
8	Cetrimide Powder	125 gm.
9	Cotton Bandage (4 cm x4 meter)	120 Rolls
10	Absorbent Cotton (100 gm each)	10 Rolls

Source- ANM module, Reproductive and Child Health Programme, Published by National Institute of Health & Family Welfare, New Delhi

III. The issues concerning job description

a. Most understand the ANMs' list of jobs as being unusually long and impossible to achieve (see lesson 3 for the list). Simultaneously, most studies show that in practice her time is spent on only a much smaller set of tasks. These are primarily immunisation and antenatal care. Other tasks allotted to her, like assistance at child-birth/deliveries and IUD insertion, take much less of her time due to much lower frequency of performance. A task that ANMs perform that is under-reported is to attend to people coming for treatment for common illnesses. Though they treat only a small part of the illness in the community, it could still mean a few cases every day that she provides curative care for. Referral for sterilization and provision of temporary family planning supplies is another task that gets done by most ANMs.

b. The male worker's tasks are even more nebulous. Most often, they are not even available - their posts are lying vacant. One of their tasks that gets performed is to accompany the ANM to the immunisation camp, and help her with the supplies. The other is in making slides – blood smears – as a part of the malaria control programme. Other than these two tasks, a survey of what work they perform would come up with a list of odd jobs. In fact, in one study, when asked to name what their main functions were and which of these they had done – there was no consistent reply.

c. Thus of the two Sub-centre workers –one (the ANM) has adequate work but can do only a part of her job description. The other is not even clear about his job description.

IV. The issues concerning workforce skills and motivation which constrain their outputs

a. Lack of skills in ANMs: ANMs have little training on mid-wifery especially on management of complications. Many of them do not know how to insert IUDs and their equipment for the same lies unused. It is almost an axiom that if in the previous year, an ANM has not done a single procedure of IUD insertion or assistance at delivery or is reporting very low (probably false) figures, she does not have the required skills. She is often reluctant to confess this and may blame it on other factors and even risk being counted as insincere rather than as incompetent.

b. Even more acute lack of skills in MPW (M): Male workers have, as a rule, had almost no training and no clear work allocation; they have received, at best, sporadic trainings of one day each. Their lack of both knowledge and skills is more acute, and their embarrassment at admitting incompetence, many times more than the female worker. On the other hand they have less problem in admitting to not doing the job sincerely (because it is often acceptable in the peer group). Thus, superficial observers tend to mistake insincerity as leading to incompetence, when in most cases it is the other way around.

c. Quality of Supervision: There is almost no on-the-job training and support for these workers. Since most problems are perceived as related to insincerity, the system believes that hard discipline will solve all problems. Civil society advocacy reiterates this idiom. Supervision becomes more an act of maintaining discipline than of providing on-the-job training and support. Thus, at all levels, employees tend to cover up weaknesses and claim false achievements rather than admit to problems. In any event, the list of work is very long and a supervisor can always find fault in case an employee does not seem to adhere to what is required of her. Thus even if an ANM is doing very good work in one of her taks, she dare not report less than what is expected of her in all the taks that appears on her job description.

d. Poor Skills and Support to Supervision: The key to the poor performance of supervision by the supervisory staff is the lack of training and support that they themselves face and the big lack of leadership or role models that they can emulate. This is not to rule out the role of maintaining discipline, but whereas discplining is well understood, the more important non-disciplinary inputs are not.

e. Unfair Practices: Failure to pay the peripheral staff money for travel, for stationery and other expenses that are their due is a cause of much heart-burn and a major de-motivating factor. This phenomenon is several times worse when an ANM or MPW (M) has to sign a voucher saying that she/he has received a certain sum of money for travel or other expenses and she/he is handed only a part of the amount. Some commentators would call this a common practice which is replicated, at higher levels. This makes a mockery of all discipline at that level, but much worse, it erodes the entire sense of purpose of the public health system. It is equal to replacing one set of goals, Health for All, MDGs etc., by other goals – personal and illegal gains.

f. Gender Issues: Some of the major problems that ANMs faces are related to the problems of women having to play a role in the public sphere in a fundamentally unequal society.

   i. *Sexual harassment* is common place and even occasional sexual and other violence against them is well known.
   ii. A major problem is that of ***walking the tight rope between family and job***. The ANM's family is reluctant to move to remote areas and without the family, child care support is impossible. Also, her children's education requires near-urban postings inherently incompatible with the nature of her task. Staying alone in a village, with a male companion, especially when the community support is negligible and even hostile to her is also a major problem. These factors together lead to what has been characterised as the *'up-down ANM'* – the ANM who refuses to stay at headquarters, who comes in the morning and leaves in the evening, often coming in late in the morning and leaving in the late afternoon. Obviously this limits access to her services and her ability to visit villages.

iii. *Often the family situation becomes exploitative and harsh, and marital break-ups* are more common in this workforce as a result. Of course for every one such story of break up there are four or five stories of very good support. Sometimes this support, given because the whole family depends on her earnings, comes with a cost – the lost of self esteem of the male elder in the family, and this brings about another set of problems.

g. Lack of Community Support: Many of all the above problems would have been ameliorated if there was a sense of job satisfaction, a feeling of having done something useful that the community appreciates. Most unfortunately, this does not happen. One of the main reasons is that almost all the services that the Sub-centre is keen on delivering have traditionally not been the community's priority. No one wanted immunisation against diseases that they have never seen – diphtheria or whooping cough or tetanus. Measles is of course common but often perceived as a visitation by the goddess. Family planning is another service and a priority that has been driven top-down in the past. Even antenatal care needs to be explained, and since it has made so little difference to maternal mortality in public perception (and even in medical statistics on outcomes) there is no great sense of gratitude for it. On the other hand, the people experience fevers and skin infections daily, and emergencies like accidents and snake bites for which the Sub-centre appears irrelevant. The image or community perception of the ANM and MPW (M) is thus of a government person running some schemes as part of a priority that the community does not share. The Sub-centre has little to offer for what their children and family members die of. Thus community support is not just a matter of changing peoples' behaviors (through BCC programmes) to accept the service being delivered. It is more important to change the services being delivered to be responsive to what people think they really need. Of course, over time people have come to believe in the importance of immunisation, antenatal care etc., but there is still a case for the system being more responsive to immediate needs to win better community support.

"Thus community support is not just a matter of changing peoples' behaviors (through BCC programmes) to accept the service being delivered. It is more important to change the services being delivered to be responsive to what people think they really need."

h. Issues of caste and community based exclusion are also a problem. The problem may lie with the MPWs or with the community, or with both. The great cultural divide between the MPW and population she/he serves, more so if the population is tribal or dalit, can be a serious problem.

THE JUSTIFICATION OF THE SUB-CENTRE AND THE POSSIBILITY OF ALTERNATIVES

Does all this mean that the sub-centre is not needed? Far from it. Any modern care provision does require the delivery of the basic functions that the sub-centre provides. All primary health care systems require service delivery at three levels, the community level, the outreach level and the facility level. The sub-center and its functions is the important outreach level of service delivery. Immunisations, antenatal care, assistance at home delivery, prompt local symptomatic care are all an essential components of outreach services.. Outreach centers also need to be able to respond to a much wider range of emergencies and curative care needs, and provide at least very good first aid. In the organisation of the outreach services along with the health sub-center, the anganwadi center also plays an equal role.

If the sub-center is not functioning adequately we need to examine the alternatives to current sub-center for the provision of outreach services and what the supplementary measures can be to improve the functioning of the sub-center.

The main alternative outreach mechanism considered, is to contract-out a "section" or a cluster of "sections" to an NGO or a private party. This, of course, is only a management arrangement, not a change of design. In almost all such arrangements, the main costs are borne by the government, reiterating that in effect this is only a management device. In urban slum areas such arrangements have become the main form of urban health care provision. The mother-NGO to field-NGO RCH programmes are also centered around such contracted-out service delivery arrangements. The issue then is whether it brings any benefits and whether such benefits outweigh the problems of such arrangements. This is discussed later in another module on Private Public Partnerships (PPPs).

An alternative (which is not so much an alternative as a supplementary programme) that government has utilized for closing service delivery gaps, is holding special outreach camps. This initiative sometimes goes by the name of alternative service delivery. NGOs or other government departments get roped in to deliver these services on a particular day, decided previously and informed to the community. The staff and supplies are transported by vehicle. This is a good stopgap arrangement for an end of the year catch up to ensure that areas that have been missed for immunization are covered quickly. However, this is a poor structure for health system and is bound to fail in the long run. As it gets repeated again its seriousness declines and soon the alternative delivery is as ineffective as the routine delivery was earlier. Still, it remains a very good approach for 'catch up' of immunization services.

The use of mobile medical units, visiting some difficult to access or under-served villages on a fixed schedule, after prior notification, is another method that has been used with some success to close gaps in outreach service delivery. Again the main limitation of this approach is that outreach services which are needed on a daily basis cannot be provided through this route. Only immunization and antenatal

care and perhaps some contraceptive services can be supplied. In particular assistance at child-birth, management of common illness, response to malaria, regular village visits etc would not be happenning

Supplementary processes that are essential for the completion of the sub-center tasks are therefore :

a. the important role of community participation and of community health workers(ASHA),
b. strengthening the role of the anganwadi worker and the anganwadi center

In addition some NGOs have worked at supporting the setting up of practices by nurses or community midwives to deliver skilled assistance at birth as well as other RCH services as a family level enterprise. The possibility of paramedical complexes providing laboratory support linked to this has also been proposed.

What is to be done?

The NRHM has opened up a number of possibilities to strengthening the Sub-centre. Let us list some of these suggestions; these are not in order of importance but in the same order in which we discussed the problems above.

1. Issues of Sanction and Location of Facility: The Role of GIS

If the absolute number of Sub-centres falls below what is required by population norms, one can represent to the state and the centre for increasing the number of Sub-centres allotted.

However in many places the number of Sub-centres is low in one district – but for the state as a whole the number of Sub-centres is correct. This sort of misdistribution also occurs between blocks within districts. Though in theory it is easy to say 'redistribute the Sub-centres', in practice, both local opposition and the cumbersome administrative work would make that difficult.

However when new Sub-centres or PHCs are being sanctioned as is happening now and occurs every ten years, there is a window of opportunity to consider locating the new ones to fill gaps. Also by converting some more Sub-centres into PHCs to close PHC gaps, some more sub-centres can be created where they are needed.

Within a block and especially within 'a cluster of villages, realignment for better location is easier to achieve, especially if we are able to take villages into confidence, if the new location is more convenient and if the Sub-centre was poorly functional at its original location.

However we still need to understand the critical role of negotiation. The current poor location is a result of various political pressures on the government of the day to locate the facility in a particular village at the

behest of local political forces. Many in the administration would view this as political interference, resent it and refuse it at first and finally be forced to give in. Others could view it as an opportunity. After all the elected representative of that area has to listen to his/her constituency and if one village is more vocal or has better access to power then naturally it may get preferred out of turn. However this often results in tribal villages or weaker sections hamlets being under-represented. On the other hand if the other villages in the area are also represented in the discussion and there is hard data available in a user friendly format to influence the discussion, then the outcome is invariably more democratic and better.

The minimum that this requires is to plot all facilities in GIS software where the maps are digitalised and the villages and the roads are clearly shown along with the population of each village.[1] Usually such a digitalised map is available and the only task is to plot the facilities onto it. Even manual plotting done on a hard copy of the maps would do – at any rate such hard copies are needed for the negotiation. A table showing all villages and population and Sub-centres in relation to this also needs to be prepared. Finally, all the villages in this area where there is a disagreement need to be consulted locally for the choice, especially if the choice is going awry. This would also result in more views reaching the ears of their representatives. When many contending demands arise then the decision making process goes back to a hard evidence-based choice.

The computer itself – however good the software is – can never make the choice and there is, therefore, little point in spending on extensive software. But a good digitised information display does influence and rationalise decision making significantly.

2. Issues of Access: Two ANMs per Sub-centre

Two ANMs per Sub-centre would reduce the geographical area that each has to cover and make access to the ANMs' services much easier. Equally important, by ensuring that they go to the field on alternate days, we can ensure that at least six days a week at least one of them is in the Sub-centre and the Sub-centre is kept open.

3. Redesigning the Work Profile: Equipping with Standard Treatment Guidelines (STGs)

a. The first step is rational distribution of the work between the MPW (F), the MPW (M), the anganwadi worker, the ASHA and to a certain extent, the community. This is described in the tables below.
b. Another critical element of this is to equip the MPWs with standard treatment guidelines in the state language, train them on these and equip them with an expanded drug list so that they are able to respond to the immediate and relatively simple health needs of the people. This brings them great credibility and makes for a big difference with a Sub-centre always open and functional.
c. Developing an indicator-based Panchayat level plan that incorporates both local needs and state and national health goals and making sure this is the Panchayat's decision. Resultantly, there would be much greater understanding and recognition of the ANMs work and if this becomes effective there could be a demand that the untied fund of Rs 10,000 per Sub-centre provided in the NRHM be increased.

4. Redesigning the Work Profile : SBA or institutional delivery?

One critical question is this – is the Sub-centre a site of skilled birth attendance or institutional delivery. The current consensus is that if it can provide all the elements of basic emergency obstetric care except for assisted delivery, and there is a referral transport link up available on call, it should be called a site of institutional delivery.[2] Thus each Sub-centre should be qualified and certified as a site of institutional delivery as most currently would not meet this requirement. In the absence of meeting this requirement – there is not much difference between a delivery conducted at home and at the facility and therefore no importance need be given to bringing patients to the Sub-centre for delivery.

The job description for both MPW (F) and MPW (M) would now read:

a. Immunisation – Children and pregnant women- largely at the village visit and camps, but supplemented by immunisation at the sub centre.
b. Motivation and facilitation for all methods of contraception
c. Training and support to ASHA and local women's health committees
d. Regular house visits, such that every household is visited once every month (or two months in difficult areas) for a set of case detection, follow up and counselling activities along with first contact curative care where required. (this includes all national programme related activities)
e. Focused group discussion/health education sessions/ health camps
f. Curative care during field visits on three days and at Sub-centres on two days
g. Response to epidemic using a graded epidemic response protocol.
h. Interaction with Panchayats and with local leaders for facilitation of health programmes.

In addition to the above, the MPW (M) would have the following tasks:

- Addressing male youth on adolescent problems and STDs control.

In addition to the above, the MPW (F) shall have the following tasks:

- Assistance at child birth
- IUD insertion.
- Ante natal care and post-partum care at sub centre – with visits to those pregnant women unable/unwilling to come

Table 4.2: Synergy between functions of MPWs and the ASHA

Functions of MPWs:	How could ASHA help MPWs?
Carry out the immunisation programme. Use data from ASHA registers on a monthly basis to update her own registers.	Maintain registers for her village which tracks which family has not received the service due.
Refer all institutional deliveries to PHC or CHC in case of complications. Provide home delivery care to as many women as possible Provide Sub-centre delivery only if it is not a high-risk case and if home environment unsuitable for delivery. Not to insist on institutional delivery at sub centres- except in special circumstances which are to be determined.	Encourage pregnant women, especially high risk cases for institutional delivery as part of her family visits and counseling work.
Provide pregnant women with complete antenatal care either at Sub-centres or at RCH camps. Attend to those that do not show up at headquarters or camps at their residence.	Encourage pregnant women to seek complete ante-natal care either at sub-centres or RCH camps.
Do survey of target couples and provide service delivery for condoms and oral pills, do IUD insertion, and bring in cases for sterilisation. Motivate all those who have two children.	Put women who want to limit family size in touch with ANMs and promote spacing and work against early age of marriage.
Provide basic curative care and follow up care to doctor initiated treatment - to be assisted by an expanded list of 30 drugs and minimal laboratory tests such as urine, blood tests. Be available twice a week at the Sub-centres for such consultations.	Provide first contact curative care – largely symptomatic- with list of ten drugs. Identifies and refers cases needing higher care early.
Respond to outbreaks of epidemics. To develop an epidemic response protocol for this purpose.	Alert health department to epidemics

Carry out health programmes in primary schools. (We recommend that two MPWs in every block, specially trained, may be spared for exclusively attending to school health work .The regular MPW cannot fit this in without loss to other work. The school health programme itself needs to be thus redesigned.)	
Train ASHA on early diagnosis and prompt treatment of diarrhea, childhood pneumonia, malaria and malnutrition.	Provide prompt treatment for diarrhea, childhood pneumonia and malaria as part of her family visits and counseling routine. Identify malnutrition and related diseases.
Attend health education meetings at village/hamlet level (particularly for adolescents and women)	Conduct health education meetings in the village, when possible with MPWs attending for health education in their villages.
Treat fever patients who come to SC or who are seen during fever survey or during house visits. Visit patients diagnosed as malaria/prolonged fever to ensure complete treatment. In coordination with local leaders and health department ensure reporting of tests within 24 hours from PHCs. Help ASHA and local leaders to organise collective action on source reduction.	Provide presumptive chloroquine treatment, take and send blood smear, if necessary. Encourage/Motivate Panchayat members to arrange speedy delivery of slides to PHCs and reporting within 24 hours and make local vector control measures available.
Get regular supplies of drugs to ASHA and collect information from ASHA. Provide regular training to ASHA on drug kit and other aspects of her work. Help involve local CBOs in social marketing programmes.	Help MPWs in social marketing programmes. Use drug kit to provide first contact curative care. Assume functions of erstwhile depot holders.
Hold RCH/health camps to close identified gaps in service coverage/health service needs.	Request for RCH/Health camps to close identified gaps in service coverage /health service needs.

5. Issues of Infrastructure and Rental

A huge outlay is needed for the Sub-centre building gaps to be closed but this is not impossible to gather. There is a case for such an outlay even if the Sub-centre is not the site of delivery for it would now be a site of outpatient care with two ANMs and because it provides for accommodation for the ANMs also.

Since institutional delivery is not the rule in Sub-centres there is not much loss in running it from a rented building. However, a clear provision for rent needs to be made and if current levels are inadequate they need to be raised. Also it makes no sense to have the same rent amount fixed for every Sub-centre on the plea that in government systems flexibility is difficult. Health sector reform requires precisely such administrative reform. The rental allocation for the district may be treated as a pooled amount with a base-line per Sub-centre and with a methodology for claiming, verifying and sanctioning an additional sum where it is required. Then one can insist on at least one room being made fully available for patient care in the Sub-centre apart from the MPW's residence.

The Untied Fund

This would go to addressing recurrent small problems of gaps in minor equipments, small tasks of infrastructure maintenance and small gaps in programme requirements. Since it is almost impossible to determine and allocate the requirements for each Sub-centre, this untied fund is valuable. Of course, all Panchayats and ANMs would find it arduous to make the purchases of such equipment which is not readily available in the market and thus giving them names of suppliers and rates would be essential. Similarly, drugs need to be sent in from district level procurement through a proper distribution system and local purchase if at all, should be a very rare exception.

The rest of the untied fund must go into implementing the Panchayat level plan and for incentivising the role of ASHA who plays a key role in monitoring and assisting its implementation. Well utilised and linked to an indicator based plan, this fund could grow till it becomes effective to achieve health goals at the local level.

6. HR issues – Recruitment, Skill Development, Career Plan, Transfers etc.

The answers for this vary and it is for each state to decide. However, facing this question in a lazy and incompetent way, which is itself not acceptable, is to treat issues like the up-down ANM and the poorly motivated male worker as inevitable, and thereby not allowing alternatives even within current constraints.

The problem at its core is that they are very junior employees in the system and their needs get little attention even when they are founding blocks of the system. Given below is a list of possible steps:

a. Get the ANM and MPW pre-service training centres functional.
b. In areas where it is difficult to find workers, especially in tribal areas, start an innovative vocational stream for girls and boys in the plus two stage of schooling that leads to ANMs and MPWs.
c. Ensure a periodical 15-21 days retraining for every ANM or MPW every 2-3 years.
d. Ensure promotions to a higher grade once after five years.
e. Strengthen the existing system of 6 months of training and then promote to supervisor grade; extend this to the male workers also.
f. At the end of five years allow those who would like to undertake nurse training access to such courses with study leave for the same- paid leave if they give a bond. (potentially after five years as nurse they should become eligible for being trained as nurse practitioners).
g. Get ANMs recruited separately for each block.
h. Ensure that transfers are transparent and non discriminatory.

The full list is still longer – but this is indicative. And this is in order of perceived difficulty, the last being considered almost impossible. And yes – it is a lot of work- but in can be done and it has been done!

7. Relationship to Panchayat and Decentralisation

This is a key issue. One suggestion is to hand the Sub-centre over to Gram Panchayats, but in which case, many Panchayats would get left out since the Sub-centre is not aligned with the Panchayat. Thus, unless there is a policy decision to have one Sub-centre per Gram Panchayat, this many not work out. Also each Gram Panchayat would have different levels of capacities and attitudes and to monitor and support them all may not be immediately feasible.

Another possibility is to hand over all Sub-centres along with the PHCs and may be even the CHCs, to the Panchayat. Thus, the staff of these facilities becomes Panchayat staff. Of course, existing staff would be treated as on deputation to the Panchayat so that their terms of service are not affected. And there would be a higher pay package for those who join as Panchayat staff – the pay being given to the block Panchayat along with the administrative staff and other resources needed for running these facilities. Panchayats could thus recruit doctors and nurses who know they have to work there and are willing to do so and they could offer higher wages if no one is willing to come – or even send one of the persons they nominate for nurse training. Later this could be made applicable even for doctor training.

As an immediate start at least the second ANM and three staff nurses to be sanctioned for each Sub-centre and PHC could be recruited as part of a block level cadre under the Panchayats.

Of course block Panchayats would require technical assistance to run a health sector, and building in a strategy of technical assistance is critical. Panchayats will find it difficult to find staff on their own unless an HR recruitment and placement agency helps them. Planning and administration would also require support.

CONCLUSION

The question arises that since most of the suggestions are mere common sense, why has this not already been implemented.

The answers lie in an understanding of governance and public administration and their influence by relationships of power. These would be discussed in a later book.

Review Questions

a. What are the causes of the 'up-down' phenomena?
b. What are the possible uses of the untied fund?
c. What principles should be followed in opening and locating subcentres?

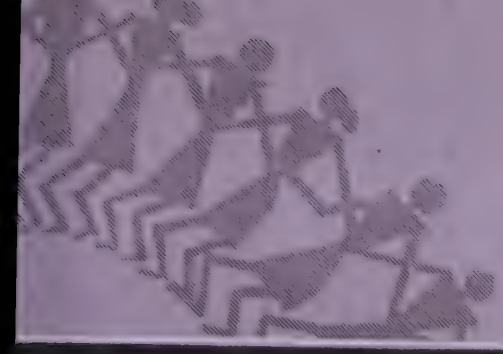
Application questions

1. What is the value placed upon the ANM in your area? Give reasons for your answer.
2. Is the MPW (M) functional? What are the reasons for this?
3. What is your opinion on handing over subcentres to Panchayats? What is the best way to involve the Panchayats? Give reasons for your answer.

Project assignment

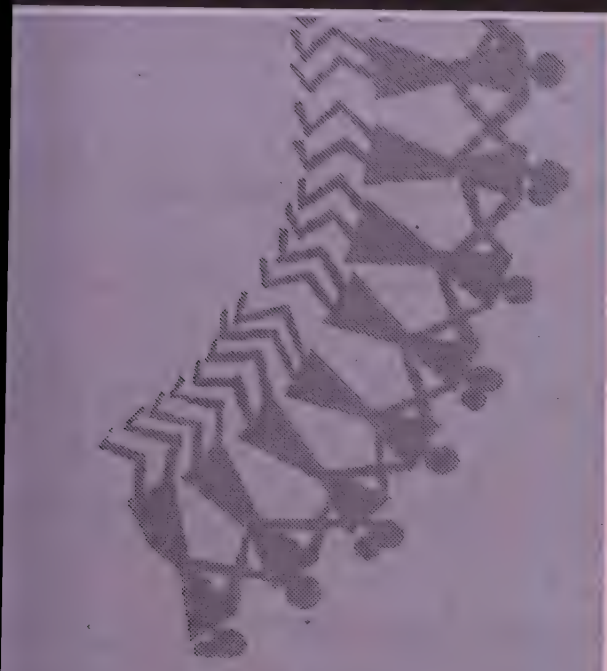
1. What is the level of delivery of Sub-centre services. Is such data available at the block level or PHC level for all Sub-centres of your area?
2. Of the problems related to Sub-centre functioning discussed in this lesson, what are applicable to your area?
3. Using the Sub-centre facility survey form in the Annexure, conduct a sample study of at least three Sub-centres.
4. Have a discussion with the MPW (M) and the MPW (F) separately. Go through the entire list of constraints on the functioning of the Sub-centre and tick off what is applicable in your area. What is not applicable in your area?

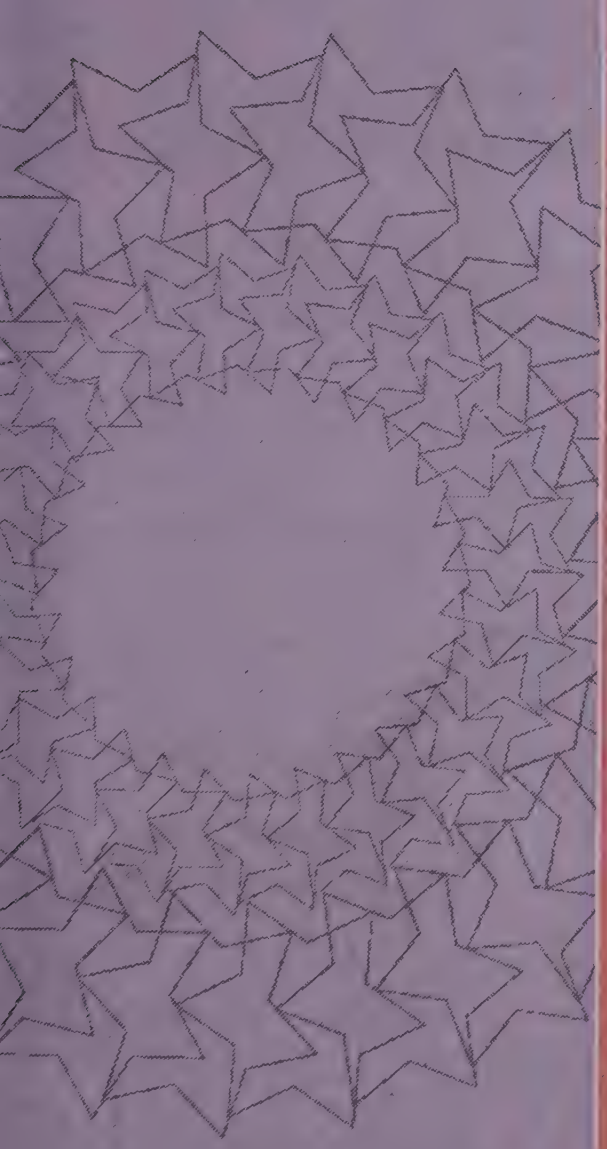
1. GIS means Geographic Information System and refers to computer software where various types of information is related to the geography and is displayed.
2. Assisted delivery refers to delivery by forceps or vacuum application.



Lesson FIVE

The 24-hour Primary Health Centre: Making it Happen!





In this lesson we shall discuss:

- The current functional status of the PHC
- The justification for one health facility at this level -the logic of the 30,000 number and the need to make for comprehensive as opposed to selective care
- The bottle-necks in making the PHC functional
- Envisaged design changes under NRHM and otherwise
- Addressing the issue of motivated 'doctors' for PHCs
- The case and route to comprehensive as against selective care

PRIMARY HEALTH CENTRE FUNCTIONING

Case Study 1

Visit Report to a Primary Health Centre:

The PHC was an adequate, even impressive building with a separate laboratory, a 4-bed ward, a minor operation theatre, cold chain facilities, a consulting room, a waiting space and a pharmacy. It even had a 3 bedroom residential quarter for the doctor. Unfortunately there was no one there except the watchman and the pharmacist and a few buffaloes that were contentedly chewing straw. Enquiries revealed that there was one medical officer posted at the PHC along with one staff nurse, one male health supervisor and one female health supervisor, one laboratory technician and a pharmacist. But of these, only the pharmacist had turned up. In the morning at about 10.00 a.m. about 20 patients had come who had all been dispensed either white (paracetomol), yellow (vitamin B-Complex) or red (iron) tablets. Suitable entries had been made in the register. The hospital beds, it was obvious, had never been used. By about 1.00 p.m. even the pharmacist had left. At this PHC, there is a system of taking turns – on about one or two days a week the doctor comes. On the other days it is the pharmacist or the nurse who take turns between themselves. The supervisors come on Saturday for the review meeting, held in the PHC premises, with the MPWs. On other days they are expected to be supervising in the field, which they do on some days. Otherwise they have no task allotted in the PHC and are therefore are not in the wrong for not turning up. The medical officer is a young man preparing to take his postgraduate entrance examinations. He did not get in the last time he tried. He has no supervisory duties over the Sub-centres, its staff or the supervisory staff and rarely attends even their review. The supervisors report directly to the BEE and the BMO.

Case Study 2

"This PHC is known to be a well functioning PHC."

This means that the doctor is present there on most days and stays there. The OPD attendance is about 50 per day, which is good. The PHC itself is in a government building; it is a Sub-centre converted to serve as a PHC and is clean and well maintained and even has a small garden outside. The main function of the doctor is to see the patients and prescribe treatment. No admissions are made as they are not equipped to manage them. He stays in rented accommodation and has been seeking a transfer for years, but has not been able to secure it. He is full of resentment and a feeling of worthlessness because of this, and even his family is critical of him. But no one wants him to resign the government job and go.

The laboratory assistant's post is vacant and no laboratory work happens. Any cases which are sick and which need further testing are referred to the CHC about 20 km. away. The PHC has two beds but the labour room is in a poor condition which is one reason that no institutional deliveries take place. The public health functions are taken care of by the supervisors who report to the BMO and the PHC medical officer's role in this work is minimal.

The medical officer himself admits that no major public health change in the area can be reported. In fact he says there is an RMP in the village who is flourishing, which he attributes to peoples lack of awareness. He also says that his drug supply gets interrupted and he cannot give injections like the RMP, and hence the effectiveness of his management is perceived to be less.

Of all the health facilities, the poorest performance today, is probably of the primary health centre. These two case studies are illustrations of typical poor performing PHCs. A superficial reading of these two case studies would lead us to believe that the problem is mainly a lack of motivation of the staff. But as this lesson will try to establish this is much more than an issue of motivation. At the core is a design problem in the way the PHC is designed and a human resource management problem.

The following is a summary of some aspects related to poor the functioning of the PHC.

- The average OPD attendance reported from secondary data is in the range of about 10-40 persons per day.
- Most PHCs do not conduct institutional deliveries.
- 2-6 beds are available in many PHCs. However, in-patient care is almost completely absent. The few admissions that occasionally do take place in some of the PHCs are for normal delivery or for fever.
- The quality of care provided in the PHC is poor. This is partly due to problems in drug supply, but primarily because the medical officer is unable to handle many medical problems in the absence of peer support and diagnostic facilities. Also since the focus is so much on a 'public health diseases', other diseases especially non communicable diseases that could make for even 40-50% of cases tend to get referred inappropriately to higher centres even where they could have been handled locally.
- The PHC plays a limited role in public health aspects- most of it directly being managed from the block, through the supervisors.

The main causes are listed in the following section.

The Crisis of the Primary Health Centre

- There is a critical non-availability of doctors for working at the PHCs;
- Even if doctors are posted, doctors do not stay at the PHC HQ;
- Even if doctors are present, the perceived quality of services rendered by them is not much higher than the RMP;
- The doctors are reluctant to play the role of leading public health work locally;
- In relationship to the number of patients seen there is an excess of paramedical human resources, most of which is underutilised. Most of the staff is designed to support the doctor and when he is absent, the entire sum spent on the PHC is wasted. Even if the doctor is present the cost per patient that it works out to is 'high' and the impact on public health low.
- There is lack of accountability to the public and lack of community participation;
- There is inadequate physical infrastructure and facilities and difficulty in maintaining uninterrupted supply of drugs;
- There is a lack of set standards for monitoring quality of care.

The above problems are well known and they are posed as if they admit of no solution. The doctor is seen as 'inherently reluctant' and at best can be forced to go the PHC but cannot be made to work there.

Therefore there is a growing body of opinions to 'reconsider' the role of such a facility. There were suggestions that all the doctors be withdrawn to the CHC level and the PHC be left to function at the level of the Sub-centre. For curative care, a linkage with the RMP is proposed. In this scenario, even functions like institutional delivery can happen in only one facility in the block – the CHC - and the rest can happen either with skilled assistance from the Sub-centre or at the private clinic.

THE CASE FOR THE PRIMARY HEALTH CENTRE

Why do we need a government health centre at the one per 30,000 norm?

The Epidemiological Reasons:

The argument for this rests in combination of the epidemiological study of disease prevalence and of the sociological understanding of health seeking behaviour. Most illness episodes can be attended to by a community health worker – but there are enough types of illness episodes that she has to see and refer, because the illness may be beyond her level of skills, the person fails to respond to the care she is giving, or because the condition worsens. Certain illness episodes need a medical doctor to attend to from the very first time the 'patient' decides to seek health care. A person with fever and fits or loss of consciousness, or a person with hypertension requires medical care from the very beginning. Thus in planning for health care it is important to know what care can be delivered at the level of the community health worker, at the level of the paramedical and what care requires a health care provider trained to a level equivalent to an MBBS degree.

Levels of Curative Care and the need for the PHC: A Study at SHRC, Chhattisgarh

SHRC Chhattisgarh undertook a study in 4 villages with a total of about 2373 population and 407 households. Of these, about half the households were from two tribal villages and the other half from two non-tribal villages. One of the two villages was a village near an urban area and the other was relatively remote from it. In the month prior to the study there were 332 illness episodes in this population. Generalising the data from these four villages we were able to make the following statement:

"In a population of 1000 we can predict140 to have <u>any</u> perceived illness in a month and the approximate pattern of illness would be 35 cases of fever, 28 of pain/headache, 14 of diarrhea, 36 with respiratory infection, 6 with injury, wound or ulcer, 6 with weakness including symptomatic anemia, 6 with have a medical non communicable problem (the range included hypertension, sickling, mental illness, epilepsy, cardiovascular disease, paralysis, cancer, goiter), 4 with skin problems, 2 with female reproductive tract illness, 2 with jaundice, and 2 with minor surgical problems."

To this statement, the study adds the caution that these figures may need considerable correction if there was a skilled person searching for certain illness through specific queries. For example RTIs would certainly be higher if a skilled nurse was asking about it and non-communicable diseases would certainly be higher if everyone's blood pressure was checked and blood tested and if obesity was considered a disease. The summary of the disease patterns presented above would have to be qualified further based on the trends seen in the inter-village difference and the effect of disease outbreaks.

The study had also noted a possible change in the perception of illnesses down an educational / awareness gradient, i.e. the more educated, near-urban households perceived and reported a wider range of illness. The principle seems to be that in some poorer and less literate communities, where wage loss is not incurred and one is able to continue with routine activities, the chances of a physical complaint being perceived as a disease may be low. This is corroborated by other studies on health seeking behaviour also. For instance, the incidence of skin disease was reported as nil in a remote tribal area, which is very unlikely if we went by more than self-perception. Respiratory illness and weakness are also reported less in remote tribal villages compared to the other villages, which is also very unlikely considering the tremendous level of malnutrition prevalent there.

Type of illness in the child under-5: Further disaggregating the pattern to look at the pattern of illness across age groups we find that in young children it is largely episodes of ARI, diarrhea and fever that occur, and after that pains and other problems also become a major feature. If, however, we are able to provide prompt attention to fever, diarrhea and ARI and prevent mortalities due to this, we would be taking care of 90% of all illnesses below the age of 5 and 71% of morbidities in all ages. This is the conceptual framework in which the content of training and monitoring of the community health worker or ASHA programme is based. Not all these cases can be managed by the community health worker- as high as 50% of those cases categorised as needing a community health worker's attention may need referral care – but knowing to which category the individual belongs, and seeking care promptly and appropriately and the measures taken till medical care is reached can make the difference, literally, between life and death. Since most of these episodes are self limiting, even a service that discriminates between those requiring referral care and those that can be managed locally, is essential and life saving especially in young children.

The Medical/Paramedical Divide

The study then examined the requirement of *medical* care, as distinct from *paramedical* care. About 29% of all morbidities would require medical attention from the very beginning and as many as half of those that the community health worker sees in her role as first contact care, may also require referral attention. Thus by the findings of this study, in a population of 30,000 (which is the PHC norm) there would be about 2400 episodes in a month or about 80 cases per day, excluding pregnancy related care which would require medical care! Of these 2400 cases some would require referral to the block hospital. We will also find that most of these 2400 cases would not travel very far to seek care for this level of ailment, for reasons of cost and perception of needs, and hence a functional sector level PHC remains a vital ingredient to achieving adequate levels of care. This 2400 therefore represents 57% of cases. The 43% that the community health worker or the ANM or the RMP manages is an important contribution – but without the primary health centre providing a level of care equal to what the trained MBBS doctor provides with a referral back up, the 57% of illness would not receive the adequate level of care required.

The study also noted that 12% had fallen through the mesh of the safety net and sought or got no treatment whatsoever.

This distinction between paramedical level of care and medical level of care must inform the strategies of human resource deployment for the public health system. This is elaborated further below.

If a paramedical health care provider gives chloroquine and an antibiotic to any fever *over a week* he would probably manage to cure a lot of patients who would potentially otherwise have died and refer the few who do not respond. But a doctor in the same situation would also simultaneously test for and rule out the possibility of typhoid, and even start presumptive treatment for typhoid if there is high clinical suspicion for the same. And even in high malarial areas only about one in ten fever cases would be malarial. Thus nine out of ten patients of fever are exposed for *over a week* to an unacceptably high risk when provided only paramedical care. The presence of the community health worker or paramedical helps and even the RMP helps to reduce the load – but it does not substitute for 'medical' help and therefore it does not substitute the PHC. Typically, therefore medical leadership has had no confidence in the RMP being able to play the curative role at the level of medical care, though it has been willing to concede him a paramedical role- at the level of an ASHA or at best a MPW. On the other hand, if we fail to differentiate between levels of care then we could be strong supporters of the RMP route to healthcare. If we include into the discussion, conditions like hypertension and epilepsy, we reaffirm the conclusion that the PHC at the 30,000 norm is based on sound principles and on epidemiological grounds.

The Social Reasons:

This one per 30,000 norm also relates to a time delay in seeking care and the distance and expense that people are willing to travel for a certain level of illness. If it is obviously life threatening and there are no alternatives available locally, the patient has no choice but to travel to wherever is the nearest hospital, for example during obstructed or prolonged labour. But if this not the case, for instance with chronic cough, a person may not leave his earnings and travel far for treatment till such time as he/she can no longer go to work.

RCH Reasons:

Another simple way of stating the same argument is to go back to the objective of institutional delivery. In a block of one lakh population there would be about 3000 pregnancies and child births including abortions, given a birth rate of 25 per 1000. If the entire load has to be handled by a single CHC it would need to cater to 250 deliveries per month – that even most district hospitals today find it impossible to manage. And above a case load of (at best) 100 cases per month, the quality of attention to complications would suffer and the quality of care would decline. The Sub-centres we have already seen are not a preferred site or even part of the plans for institutional delivery. With 3-4 well dispersed and well-located PHCs taking up some 150 cases between them, the goal of meeting institutional delivery needs can be reached.

Disease Control Reasons:

This same argument can be raised for the management of tuberculosis. If there is only one place in a block to visit for TB treatment, and getting there means a loss of one or more days of livelihood and considerable expenses, then the person with TB symptoms would delay going till he/she can no longer work. But if there are four or five places where this service is available then the visit is very likely going to be made earlier. With malaria, if all the blood smear examinations have to be done only at the block level, there would be over 500 smears reaching there per day which is impossible to report on.[1] In current times, there is a huge back log at the CHC laboratory which is impossible to manage. Where the PHC microscopy centre is not functional, the entire blood smear examination system has just become non functional.

If there are a number of private sector clinics in this sector of 30,000 people, these facilities could, potentially, be recruited to play the role of the PHC. However the presence of private sector clinics below the block headquarters or towns is low. If one considers that a situation where a private centre is available to play the role of a PHC will be an exception, the invariable conclusion that one reaches is that there is no alternative to making the PHC viable for the purposes of providing 24 hour institutional delivery services and microscopy centre services, if we are to attain our immediate public health objectives.

The case for Comprehensive Care:

The corollary of this – that should not be lost on any administrator - is that if we build up infrastructure, manpower and equipment to provide 24 hour skilled assistance and basic emergency obstetric care and a microscopy centre, then with almost the same investment and skills, the facility would work for comprehensive care. It would provide treatment to not only reproductive and child health problems or diseases which are part of national disease control programmes, but for the entire range of illness including non communicable diseases. It is not the equipment but the presence, skill and confidence of the health care provider that is the critical bottleneck in providing comprehensive care. This would be professionally more satisfying to the health care providers, more useful to the patients, and give a higher status and credibility to the PHC. The health administrator may see this as full utilisation of an investment that is already committed, instead of seeing provision of comprehensive care as distracting from a narrow understanding of reducing infant mortality and maternal mortality rates as the sole purpose of the health system.

SAVING THE PRIMARY HEALTH CENTRE: MAKING IT A CENTRE OF COMPREHENSIVE 24 HOUR PRIMARY HEALTH CARE

Making the PHC a centre of providing comprehensive 24 hour health care requires that one is convinced of the *need* to have a functional PHC. Only if we start with this as a non negotiable can we come up with ways to make the PHC functional.

What are the current problems in making it functional?

A. The Medical Officer and the Medical Role

The most important issue is the availability, the regularity and the functioning of the medical officer.

The Problem

Can we force doctors to serve in remote areas? Should we force doctors to serve in rural areas? Will forced doctors provide quality service, especially if those who can be forced are new recruits with little power to resist and little skills or confidence to deliver? The view seems to be that it is not possible to get doctors who have been serving for many years in urban centers with private practices, to relocate even temporarily. Unwillingness to go beyond the suggestion of "mandatory rural posting" option, objectively therefore, becomes a status quo position. We need to look at the possible answers to this old problem:

The Possible Solutions

The options to find doctors to serve in rural areas are:

1. *Incentivisation*: A higher salary is one of the best incentives for getting doctors to serve in more difficult areas. But the concern is how to introduce this without setting off a chain reaction in all government staff working in such areas? How does one ensure that after paying this higher amount we are able to actually get the doctor to stay there and provide quality service? One route is to allow for a substantial monetary incentive which is performance based and varies according to the difficulty of the area. The conditions for this performance based incentive are kept at easily achievable levels, for example, OPD attendance and based on this, payment of incentive are made through the block health development committee. This would be along with a non-practicing stipulation. One can add a second performance based incentive for reaching a minimum desired quality of service as per declared norms. This should be decided by a professional external accreditation agency once the application is forwarded by the hospital development committee. 75% of salary should be given additionally as a bonus plus as non practicing allowance. Other perks like eligibility for more leave etc. would also be of help.

2. *Decentralisation Related Options*: Considerable flexibility in recruitment and support policies can result from decentralising decision-making on recruitment and financing to district or block Panchayat or hospital development committee levels. This can also be used as an option only for the medically underserved remote areas. After identifying such areas based on clear criteria, these should be notified and powers for flexible rules of selection and incentivisation could apply. One option is recruitment by the local body. The selection would be for the facility and

non transferable. A state level placement agency or an NGO could assist Panchayats in finding the right staff and negotiating terms of service. Another option would be for the Panchayat to enter into a contracting arrangement with an NGO or private sector partner, with the department playing a quality assurance role. A third is for the Panchayat to offer incentives to government doctors willing to work there. Or the Panchayat may allow pooling of the doctors at the block headquarters (see below) or select nurses of paramedical staff for undergoing skills upgradation to provide medical skills (see below).

3. *Pooling the Block Doctors*: This proposal is for allowing PHC doctors to stay in the nearest CHC at the block head quarters where he/she does night duties twice a week, and from where she travels daily by vehicle to serve 7 hours in the day at the PHC on at least 5 days a week. This means that we are agreeing to the PHC having no doctor at night but in return getting an assurance that we would have one for every day.

The options to find doctors to serve in rural areas are:

1. Incentivisation
2. Decentralisation Related Options
3. *Pooling the Block Doctors*
4. *Doctor Alternatives*
5. *Compulsory Rural Service*
6. *Fair (Non-Discriminatory) Transfer and Promotions Policy*

4. *Doctor Alternatives: eg Nurse-Practitioners*: A long term solution- the lateral entry option- is for creating nurse or pharmacist practitioners in this area. We need to identify and admit in a special medical college, a batch of young ANMs/nurses/pharmacists. They must be already working and settled in these areas, be willing to continue working there and be trained to become equipped with curative skills equivalent to a MBBS doctor. They could be allowed to skip the first one-and-half years of MBBS training or it could be condensed into a shorter programme. The Nursing Council can certify nurse practitioners. If the staff nurse strength in the PHC is increased as envisaged in the NRHM, this strategy would become that much easier to implement.

5. *Compulsory Rural Service*: Making two years of rural service in public hospitals compulsory for admission to a post graduate course in any medical college has worked in some states and been difficult to implement in others. Where only a bond is signed at the time of joining the course, it has not been possible to get doctors to commit to it after their post graduation or even after MBBS.

Quality of service is also difficult to ensure. However this is a good measure that helps in a limited way for a limited time.

6. *Fair (Non-Discriminatory) Transfer and Promotions Policy*: One fundamental strategy would be to introduce reforms in workforce management policies and in regulation of private practice as means to enhance doctor availability for rural areas. These are considered very difficult to ever achieve.

B. The PHC Design

Is the PHC failing because it has some basic design problems? What does the NRHM envisage as corrective measures? And what further action can be considered?

The Problems

Under utilized manpower:
The PHC, as a 24 hour service provider, does have a design problem. It has about 7 to 10 staff members (nurse, dressor, compounder, laboratory technician, two sector supervisors, and two multipurpose workers plus some more male workers) most of whose role is to support a medical doctor in providing services.[2] If the medical doctor is absent, as is mostly the case, then all of them have little to do. If there is only one medical officer posted there, some degree of absence is inevitable and at that time all these staff are, by virtue of their role definition, unemployed. We also know that absenteeism of the doctor is high and that would further justify absenteeism or lead to redundancy of these staff members. Even if he were there and functioning well, he would be able to see only about 50 patients per day and that means a dressor would have about 5 patients per day (one hour's work per day), the laboratory technician about 5 to 10 specimens to see (another hour's work) and the pharmacist will have enough work for about one hour per day. So underutilisation is inherent. Moreover one or the other of these posts would be vacant and that would become an excuse for the poor functioning of the PHC as a whole.

Of the two supervisors located in the sector PHC (at least one male supervisor and one lady supervisor) and there is not enough supervision work for more than one supervisor. Clearly at least one of them is available for contributing to the functions of the PHC and indeed both of them can give some time. However they are often not allotted such a role.

Also the MPWs in the Sub-centres under the PHC have poor work allocation and some of them at least are available for working in the PHC if needed.

In addition to all of this, each PHC also has a Sub-centre embedded within it or in the same village, for looking at Sub-centre level work. The ANM and MPW of this Sub-centre is also available for at least performing skilled assistance at child-birth which is one of her functions.

Obviously such a system is not cost effective – it is very unlikely for instance that a private clinic would survive if it were structured like this. The focus should be on how to train, re-allocate roles and support so that all these staff members - both PHC staff and sector supervisors - have a 7 hour working day and that between them there is a 24 hour functional PHC.

Other design issues:

The 4 to 6 beds: Clarity is also needed as to what the present 6 beds at the PHC are for, i.e. the nature of inpatient care to be provided at the PHC.

The lack of referral link with community level and outreach level health service providers: We also note that attendees in PHCs are largely from the village where it is situated but not from other villages which it covers. This occurs since there is no system of community level care being provided locally and therefore of a PHC acting as a referral back up to the community level care giver.

The lack of clear service delivery norms: The other design problems are that the service delivery norms expected of a PHC are not clear and have faded from memory.

NRHM Solutions

Under the NRHM a set of proposals are being thought about with considerable flexibility for local adaptation to handle the issues which we have reviewed above:

1. *Indian Public Health Standards*: Indian Public Health Standards (IPHS) are being adopted for the PHC. The overall objective of IPHS for PHCs is to ensure availability of a minimum package of health services and an adequate quality of health care. These standards would thus help monitor and improve the functioning of the PHCs. Requirements are being projected on the basis of 40 patients per doctor per day, the expected number of beneficiaries for maternal and child health care and family planning, and about 60% utilisation of the available indoor/observation beds (6 beds). It is expected to be a dynamic process in the sense that if the utilisation goes up, the standards will be further upgraded. The standards now specify what services would be delivered, what civil works infrastructure is needed, what staffing pattern and equipment is needed and what drugs and supplies are needed. As regards manpower, the IPHS standards proposes **two medical officers** (the second medical officer may be from AYUSH or may be reserved for a lady doctor) and a total of three staff nurses (currently one is sanctioned), bringing the total staff strength to 15 in the PHC to make it a 24x7 services delivery centre.

2. *Increase in Nursing Staff*: Each PHC would have at least three staff nurses. The central government would pick up the costs of this. Three well-trained nurses, who work in shifts, would be able to

provide 24 hour skilled assistance at birth. This would be in addition to the lady supervisor in the sector and the ANM posted in the PHC and in the Sub-centre located in the same PHC premises.

3. *Development of Standard Treatment Protocols* for primary health centres that match the level of services aimed for, and the degree of laboratory support and skills that would be available. These are ideally done at state level, though a national protocol or one from a similar state in terms of levels of development could be used with a little modification.

   The goal of institutional deliveries requires a functional labour room and at least four beds with relevant support facilities- toilets, stores etc. If 24 hour functionality of the PHCs is achieved, the four bed facility would be useful. One needs to earmark these beds essentially for institutional delivery or for observation during day time while awaiting referral transport, and for some occasions like an epidemic. These PHC beds should not be mechanically counted as part of a bed occupancy rate calculation – unlike the CHC where the high bed occupancy rate is an important consideration. As a rule, the PHC is not a site of inpatient care. However in large and difficult blocks where the CHC is far away, one can consider upgrading a PHC to be a 6-10 bed PHC which would have all services like a CHC except for major surgery. Where surgical care is also possible it would be welcome.

If 24 hour functionality of the PHCs is achieved, the four bed facility would be useful. One needs to earmark these beds essentially for institutional delivery or for observation during day time while awaiting referral transport, and for some occasions like an epidemic.

4. *Facility Development Committee and Decentralisation*: Another major NRHM suggestion is for each PHC to have a registered hospital/facility development committee with participation of the Panchayat and public representatives. The hospital development committee would have an untied fund that could be used for improving service delivery and amenities in the PHC. The major source of funds would be a NRHM or state government grant, though it could be supplemented by donations from patrons and to a lesser extent by user fees collected. An alternative could be to place the PHC under the administration of the janpad Panchayat, along with necessary powers and resources, but this requires far more political will than the establishing a facility development committee.

5. *Rationalising Utilisation of Paramedical Staff*: These paramedical staff can be multi-skilled and put on shifts so that they can manage some curative care (first aid and a fair part of medical care

as laid down in a paramedical guide book or curative services), some laboratory work, and some amount of dressing and drug dispensing. This multi-skilled paramedical can be a new cadre made by merging all support cadre available in the PHC. But since the creation of a new cadre is a difficult step and well beyond the present powers of the district - it is better for the district to train and multi-skill all available support staff and MPWs in the PHCs and then empower the medical officer to allot duties and functions to each individual staff member according to the need and local assessment of capabilities. Thus even with less staff and a few vacancies the PHC would be fully functional. Since the laboratory work expected in the PHC is limited even the medical office should be able to provide on-the-job support/training to whoever has been multi-skilled to provide laboratory support in addition to the initial training. Similarly the curative work is only of a level that the trained health worker level and this uses about 25 common drugs and an especially designed paramedical standard treatment guidelines. All the staff would be able to do all the above, but the female staff in addition can assist in child birth and help with access to family planning services especially IUD insertion.

6. *"Para-medicalising" the PHC*: This idea has not yet been proposed by the NRHM but is one of the useful suggestions of National Commission on Macroeconomics and Health. The goal is to design in such a way that even if the doctor is not there, the PHC should be open and be providing quality primary health care round the clock. At least two paramedical staff, at least one of whom is a skilled nurse or ANM, should be available on shift round the clock. They should be skilled to manage basic emergency obstetric care and basic care for other emergencies and call for transport and refer where needed. At least during 7 or 8 hours of the day, a doctor would be made available – and at other times he could be available on call. But even if the doctor is absent, much of the care that can take place at this level would happen. One of the doctor's main roles would be to build up the quality of the paramedical staff to deliver such 24 hour services and monitor the achievement of such skills. The goal is also that for every employee we are able to demonstrate that there is a 7 hour working day and that by multi-skilling we rationalise the workforce so that the PHCs becomes cost effective. If the medical officer is able to provide on-the-job in-service training in addition to multi–skill training programmes then considerable advance can be made. This is not retreating to a non doctor PHC, because simultaneously the move is for two doctor PHCs.

"At least two paramedical staff, at least one of whom is a skilled nurse or ANM, should be available on shift round the clock. They should be skilled to manage basic emergency obstetric care and basic care for other emergencies and call for transport and refer where needed."

Implications of Multi-skilled Paramedics

The transition is not going to be easy, as re-skilling a dresser or compounder or MPW or even a health supervisor is likely to pose more difficulties than we could imagine now. We note that entry level basic qualifications for almost all these cadres have been school final examinations and technical skills required have been specified only for the MPW (F). A good quality in-service training of one month should be adequate to initiate this. After this, on-the-job supervision by the medical officers who are themselves retrained for this purpose would be the key to achieving this. The medical officer is stated to be the leader of the PHC team, but in order to realise this in practice, the logical starting point is for him/her to be made capable of building a team with all the requisite skills needed for a functional comprehensive PHC.

Pre-service paramedical courses also need to be reviewed. Today most of these are designed to turn out poorly qualified and even hazardous curative care practitioners of allopathic medicine. Some courses concentrate on a single paramedical area. It is recommended that all paramedical courses on offer be redesigned to regenerating multi-skilled paramedical workers suitable for the restructured PHC. This would be beneficial not only to the public health system but also to the private health system in the medium term and the long term. Almost all small scale private nursing homes and clinics are assisted by such 'multi-tasked paramedical workers' with no qualification whatsoever – many of whom set up later as 'village doctors'. This suggestion should also be viewed in the light of the fact that this is already happening. Many of the functionaries at PHCs such as compounders, LHVs, or pharmacists, are not engaged in their respective job description anyway- certainly not for the whole day. We also note that this does not eliminate the need for laboratory technicians. In fact the qualified laboratory technicians could play a more specialised role at higher level, namely at CHCs and district hospitals thus decreasing the vacancy position. It should be noted that in the above suggestion there is no reduction in the number of staff at PHC involved, and in real terms since many posts are vacant there would be an increase required. In most other categories we are looking at only in-service retraining.

C. Other PHC Issues

- Lack of sanction to meet norms: A large number of sectors do not have primary health centres, so in effect a primary health centre may cover more than one sector. For example, data from the districts of Chhattisgarh shows that there are 748 sectors (i.e. 748 geographical units of 30,000 or 20,000 population) but only 517 PHCs in them - a serious shortfall of 231 PHCs. Every CHC should have about four PHCs under it- more if the population of the block is over 1.2 lakhs. Yet there are many CHCs with only one PHC and many with only two PHCs.

- Lack of Infrastructure: Many PHCs are housed in Sub-centre buildings which have been recently upgraded to PHCs. This has meant displacing the ANM from her accommodation and lack of accommodation for all. Many PHCs are still in rented space and usually have inadequate space.

- Infrastructure related issues: Very few PHCs have regular supply of power, especially in tribal areas; they also don't have any power back up to maintain cold chain. Regular water and adequate toilet facilities are important gaps. Telephone, wireless communications and transport links are also in poor shape.

  If we define a PHC as having the capacity to conduct institutional delivery on a 24 hour basis for high risk cases, all the above - patients toilets, staff toilets, bathing facilities for patients, waste disposal facilities, communication facilities for referral etc. – are essential features. Clearly this has not been achieved so far.

- Issues of Adequacy of Drugs and supplies: Many studies have shown that drug supply to the PHC is interrupted with long breaks when essential drugs are not in stock. Availability of laboratory chemicals for basic tests fare the worst. The key bottleneck is that the distribution of the drugs is still by a fixed quota of drugs and supplies, irrespective of the particular PHC's functionality and consumption patterns. A fixed amount of funds available for drugs and supplies purchase could also be the problem.

- Lack of Laboratory services: The basic laboratory services provided at the PHC must include blood haemoglobin estimation, total count, differential counts, bleeding time and clotting time, blood smear examination for parasites, urine examination for albumin, sugar, ketones, bile salts and pigments, microscopy of urine, sputum acid fast microscopy, grams staining of sputum, CSF etc. and stool examination for ova and cysts and hanging drop examination of stools. This set would be the norm for any basic laboratory. Because of local disease profiles, some tests like sickling test in some areas could also be part of the services offered. Surprisingly, there is a near complete absence of such an array of tests being available- even blood haemoglobin estimation- a test, which is a must, even at the Sub-centre level. Laboratory services are the cornerstone of scientific medicine and one of the key elements that differentiate RMP practice from that of the trained doctor. In practice most PHCs have just dropped out of the practice of doing laboratory tests. The medical officer would only need a one-week package to be refreshed on laboratory work if there is a good text to follow along with teaching materials organised well. Charts and guidebooks that both doctors and multi-skilled staff can refer to along with pictures of microscopic appearances, should also be available in every centre and their absence is a serious remediable problem.

- Referral Systems: There is no active referral system in place. The current practice is that if a patient has to be referred he is told verbally to go to the higher centre. Occasionally, a written slip is given. But this is not a referral system. There is no feedback from referral institution to the person referring enabling the patient to be primarily managed at the lower centre. There is little clear understanding of who should be referred leading to a very high degree of unnecessary referrals, thereby overloading district facilities or pushing the patient into private nursing homes.

- Professional Motivation for Doctors in PHCs: Continuing medical education for medical doctors to upgrade their knowledge and skills is a must. This should replace the current practice of upgrading their knowledge through sporadic camps of national disease programmes. The envisaged CME scheme should also be useful for promotions. Skill upgradation programmes are a must. The feeling of professional dissatisfaction may be higher especially in postgraduates posted in primary health centres and needs to be addressed through better professional opportunities. For example, they could be linked to CHCs which they attend on certain occasions, be allowed to perform elective operations on certain days, be allowed to send investigations to higher centres directly, have access to drugs related to their field of specialisation, which normally one would not expect a PHC doctor to handle etc. As a general principle no postgraduate, especially on the surgical side, should be left without being able to consult/work in his speciality area at least once a week.

- Training Ayush Practitioners: If Ayush doctors are playing medical officer roles the needs for intensive skill upgradation programmes should be recognised. There is also a large number of staff in the Ayush side, now moved to work in PHCs, who would also need such multi-skilling.

- Training of Paramedicals: Training requires to be sustained as a regular programme and not be driven sporadically by funds available from above. Thus all PHC support staff have an induction training of one month which also multiskills them, and then a refresher of 15 days once in two or three years. When MPWs, male or female, are promoted they would be required to undergo a six month training which enhances their skill levels so that now they can act as trainers, and supervisors and administrators in addition to their roles of being paramedical workers. Currently the MPW (F) has to undergo a six month training for promotion – but unfortunately the male worker who needs this even more has no such requirement.

CONCLUSION

Finally, many of the ideas above are not new and the bottlenecks will not go away easily. One possibility therefore is to start with a few blocks and close all hard gaps and training gaps and push till services improve, then move on to the next set of blocks. This block by block planning, such that all block are improved within 5 years, is the approach that the NRHM has also taken. Otherwise much equipment is bought and infrastructure is built with so many mismatches and so little attention to manpower planning and skills that the net result is a considerable wastage of resources that a poor country planning for the health of the poor can ill afford.

Are private – sector partnerships an alternative? Would it not be easier to contract out these services to any private sector or not- for- profit institution that would undertake the entire task of managing these centres and ensuring adequate service delivery?

There are many efforts in this direction and within a few years the evidence of how effective such a strategy would be will be clearer. For now the broad understanding is that where such a possibility exists – for an existing private or not for profit clinic to play the role of PHC- this could be facilitated, especially where the PHC is not functional. But if we need to shift to a policy of promoting private sector to take over what the public sector has been providing, one needs to construct a policy framework for this. Even then, for the purposes of this lesson, many of these key bottlenecks would merely be transferred to the responsibility of the private management but not really solved- unless some of these suggestions are acted upon. Even on decentralisation, the question would be whether the block Panchayat or the state or district societies would enter into the contract. These issues and the problems and possibilities of such partnerships are discussed in detail later in the module of public private partnerships.

Review Questions

a. What are the key bottlenecks in making the PHC functional?
b. What are the possible reasons for planning for a mainly outpatient and medical facility at this level?
c. How does the PHC contribute to reducing maternal mortality, and in tuberculosis and malaria control?
d. What are the options for closing the medical skills gaps for PHCs.
e What does the design problem of the PHC refer to?
f. What are the key NRHM proposals to strengthening the PHC.

Application Questions

1. If you were to undertake a massive multi skilling programme in your district, who are the groups of people likely to oppose it and why? How would you persuade them to support this programme?

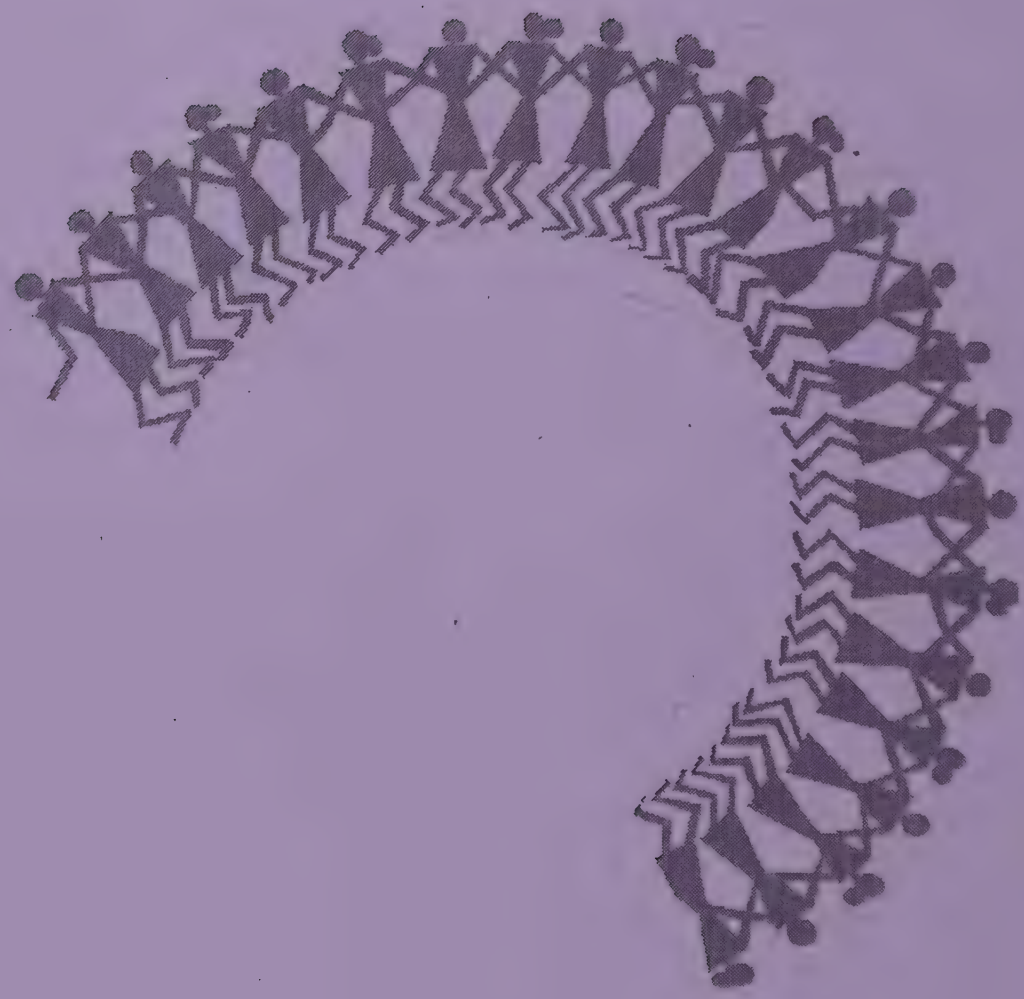
Project Assignment

1. Which of the above problems are applicable to the PHCs in your district. Find out the situation in each of these aspects by asking a PHC medical officer and a senior district level health official. For example is there a standard treatment guideline available. Are there sectors without PHCs etc

2. Do a facility survey in the block of one or more PHCs using the form given in the NRHM website or the CHRM website (www.shsrc.org). Write up a note on what you think needs to be done to strengthen the PHCs in your district. You would have to discuss these suggestions with officers to find out their views on each of them.

1. Actually we can expect almost 3500 cases of fever on any day from the above case study.
2. This includes the Staff nurse/ANM, dressor, compounder/pharmacist, laboratory technician, plus at least two class IV staff.

NOTES



Lesson SIX

Community Health Centres

In this lesson we shall discuss:

- The services expected of the CHC
- The bottlenecks in establishing these services
- IPHS standards for CHCs and their usefulness
- What can be done to overcome bottlenecks and what is proposed in NRHM

INTRODUCTION: CHCS, FRUS, CEmONC CENTRES - UNDERSTANDING THE TERMS

In the three tier health care delivery system, District Hospital and Community Health Centres (CHCs) are considered as secondary level facilities.

CHCs are usually located at the block headquarters, catering to the needs of about 120,000 population in non tribal areas and about 80,000 in tribal areas. By norm CHCs cover about 4 Primary Health Centres and about 20 Health Sub-centres.

CHCs are 30-bedded facilities with Operation Theater and Labour Room. These CHCs are designed to be the First Referral Unit (FRU) for the cases referred from the Primary Health Centres, health Sub-centres and community health workers, and are built to provide specialist care in Medicine, Obstetrics and Gynaecology, Surgery and Paediatrics and manage a set of common emergencies including Cesarean section. However since even many district hospitals are unable to provide this level of care, governments often refer to any hospital providing this level of care as an FRU - including district hospitals, civil hospitals and medical college hospitals. This is confusing, for medical college hospitals are strictly second referral units. However, the term FRU has become an expression of the facility's capability to do C-section at least, and any unit that can do this is termed an FRU.

In RCH-I a major activity – perhaps the most important activity – was the development of FRUs. This was however not achieved in terms of service delivery even after considerable investment, but since the infrastructural inputs had been delivered, the FRUs were considered as built.

Under RCH-II which started in April 2005, there was a need to define centres that would perform Cesarean section as centres that provide Comprehensive Emergency Obstetric and Neonatal Care (CEmONC centres). This is identical with the concept of FRU and many CHCs had previously already been declared as FRUs, but to keep the expected outcome more focused, CEmONC centres were retained as the objective under the RCH-II.

With the adoption of the IPHS standards for CHCs it is now clarified that every CHC is to become a FRU and an CEmONC centre, and it may be more useful to merely talk of CHCs which have obtained IPHS standards in service delivery and those which are yet to do so and build a road map by which eventually all CHCs would have this capability.

SERVICES TO BE DELIVERED BY CHCS

The Indian Public Health Standards have defined the services that a CHC has to assure.

The IPHS service delivery norms for the CHC:

1. Care of routine and emergency cases in surgery:
   - This includes Incision and drainage of abscesses, and surgery for hernia, hydrocele, appendicitis, haemorrhoids, fistula, etc.
   - Handling of emergencies like intestinal obstruction, haemorrhage, etc.
2. Care of routine and emergency cases in medicine:
   - Specific mention is being made of handling of all emergencies in relation to the National Health Programmes as per guidelines, like dengue, haemorrhagic fever, cerebral malaria, etc.
3. 24-hour delivery services including normal and assisted deliveries
4. Essential and Emergency Obstetric Care including surgical interventions like caesarean sections and other medical interventions
5. Full range of family planning services including laparoscopic services
6. Safe Abortion Services
7. New-born Care
8. Routine and emergency care of sick children
9. Other management including nasal packing, tracheostomy, foreign body removal etc.
10. National Health Programmes (NHP) components to be delivered through the CHCs.
    - In RNTCP: CHCs are expected to provide diagnostic services through the microscopy centres which are already established in the CHCs and treatment services as per the Technical Guidelines and Operational guidelines for Tuberculosis Control.(Annexure 2a of IPHS standards documents)
    - In HIV/AIDS Control programme: The expected services at the CHC level are being provided with this document which may be suitably implemented.(Annexure 2b)
    - In National Vector –Borne Disease Control Programme: The CHCs are to provide diagnostic and treatment facilities for routine and complicated cases of malaria, filaria, dengue, Japanese encephalitis and kala-azar in the respective endemic zones. (Annexure 2c)
    - In National Leprosy Eradication Programme: The minimum services that are to be available at the CHCs are for diagnosis and treatment of cases and reactions of leprosy along with advice to patient on Prevention of Deformity. (Annexure 2d)
    - National Programme for Control of Blindness: The eye care services that should be available at the CHC are diagnosis and treatment of common eye diseases, refraction services and surgical services including cataract by IOL implantation at selected CHCs optionally. 1 eye surgeon is being envisaged for every 5 lakh population. (Annexure 2e)
    - Under Integrated Disease Surveillance Project, the related services include services for diagnosis for malaria, tuberculosis, typhoid and tests for detection of faecal contamination of water and chlorination level. CHC will function as peripheral surveillance unit and collate, analyse and report information to District Surveillance Unit. In outbreak situations, appropriate action will be initiated.(Annexure 2f)
    - Other Functions:
      - Blood Storage Facility
      - Essential Laboratory Services
      - Referral (transport) Services: (details given in Annexure 2g)

Discussion

Compared to the above, if we check with the situation in the districts, most CHCs have still a long way to go. So how well CHCs function overall is not that interesting a question. A more pertinent question will be - which CHC has gone the furthest and how many district hospitals have reached this level. So even if only a few steps have been taken – we should try to estimate which has made the most progress.

Now compare the level of services currently available in the CHC with what the IPHS standards for PHCs are. We will probably find that most CHCs are able to make the grade for PHC standards. Can we thus conclude that essentially most of them are PHCs operating under a different name, and though they were upgraded on paper, the strategy to carry out the upgradation in practice was never adequately worked out – except for providing funds to close the input gaps as was the main thrust in the RCH-I programme.

What are the constraints in reaching this higher level of functionality? And though one constraint is the availability of specialists, it would be interesting to find out whether higher levels of functionality can be attained even where specialists are available.

The Bottlenecks

A. Specialists

The single most important constraint has been the availability of specialists to work in these facilities. The causes for this specialist shortage are many:

- In some states not enough specialist posts have been sanctioned and not uniformly in all CHCs either.
- The remuneration package for specialists is on a notional parity with other departments in a manner where the IAS is to be kept on the top of the pile. This adversely affects the search for specialists for CHCs, because their market rates and status are much higher than what is offered to them within government service. This is also one reason why private practice is allowed in many states
- Even where posts are created, specialists are reluctant to join or serve in remote areas, though few block headquarters are very remote in absolute terms any longer.
- Surprisingly, even where specialists join, many are specialists by qualification, but not by designation and are posted in primary health centres where they lose their skills, while many CHCs go without specialists.

B. The other bottlenecks

- One CHC per block norm: The total number of CHCs should be as per population norms and not by administrative blocks. In practice the norm is the latter. In large blocks with population over 100,000 or where geographic problems seriously compromise access to the CHC, a second CHC or an upgraded PHC may need to be considered. There are blocks which are over 80 km wide and with a population of over 200,000, where one CHC is clearly not adequate.

- Infrastructure constraints: Improper water and power supply, no separate toilets or bathing facilities for men and women staff and poor waste disposal and sanitation arrangements are some of the common problems related to infrastructure at CHCs. The lack of a functional operation theatre is often another constraint. Quite often this lack is due to a well-built existing operation theatre getting damaged from lack of use and lack of maintenance, or more precisely, neglect. Also many CHCs have only 6-10 beds and have not yet been upgraded into 30 beds. We note however that in terms of service delivery, the presence of only 10 beds and not 30 has seldom been a constraint. There are very few CHCs in the country who are referring away patients due to full occupancy of existing beds.

- Lack of communications and transport especially non availability of telephones or ambulances is another problem.

- Accommodation: The gaps in accommodation for staff are also huge. Providing staff quarters for a small part of the staff is not adequate and availability of good accommodation on rent in many block towns is also limited.

- Quality laboratory services: These are often not available. Most CHCs have laboratory facilities available, but only at the sort of levels that one expects at the PHC. That so many centres have got used to providing curative services without laboratory support, is not a good sign. It not only leads to irrational and wasteful over-medication, it also represents a mindset about quality in curative care, which needs to be addressed.

What does the NRHM Propose on CHCs?

The NRHM has four major strategies to achieve the goal of having a functional CHC at every 100,000 population. These could be enumerated as follows:

a. The adoption of IPHS norms and a block-by-block approach to reach service delivery outcomes
b. The strengthening of the Hospital Development Committee
c. Multi-skilling for closing specialist gaps
d. Private Sector Partnerships

Attaining IPHS Norms in a Block wise Fashion

Under the NRHM each state is being provided with adequate resources to upgrade existing CHCs to IPHS standards in two CHCs every year. Though Rs. 40 lakhs was provided per CHC in the first year, potentially what ever is needed could be got.

The aim of giving it to two blocks instead of making a general allocation to all CHCs is because past experience has shown that when the money is spread out thin, every CHC receives something but on the whole CHCs continue to have critical gaps that justify its non-functioning. By taking a block at a time – one can close all gaps in a systematic and focused manner so that 'there are no further excuses left'.

The danger in this strategy is that old habits die hard. Since IPHS standards propose higher levels of civil works infrastructure and equipment than had been hitherto planned, there would be a rush to spend further on such inputs. But investments on fundamental aspects such as the need to plan for human resources, to recruit manpower or increase skill levels or motivation levels may just not get made, even though the Rs. 40 lakhs sum is meant to address these issues also. In many centres the infrastructure is adequate to deliver all the services aimed for, but instead of closing these other gaps the money flows into making 10-bed hospitals with less than 10% occupancy into 30-bed hospitals. Thus IPHS ends up becoming not a set of services that are guaranteed but an expression of maximum inputs/funds that such a system can absorb. An insistence that the service delivery must reach an acceptable and agreed-to level in one set of blocks before the programme is extended to the next set of blocks would bring more attention on outcomes.

The strength of this strategy is that the IPHS norms are getting popularised and there is now a much better understanding of what a CHC should be. With some more emphasis on publicising the services delivery outcomes, the relationship between each input and the expected outcome would become clearer.

The Strengthening of the Hospital Development Committee

Another key strategy of the NRHM to improve CHCs is to strengthen the Hospital Development Committee, also known as Rogi Kalyan Samitis after their fore-runners in Madhya Pradesh. In principle the Hospital Development Committee allows for four possibilities:

- It provides for public participation in hospital management, thus facilitating its functioning and making its functioning more accountable.
- It allows for providing the hospital with an untied fund that can be used to develop and implement its own development plans. These annual plans could help achieve the quality standards and service delivery outcomes expected of it, and could prove to be a major route of fund absorption.

- It allows for a decentralised way of addressing gaps including human resource gaps. For critical human resource gaps, the Committee could negotiate contractual appointments or enter into MOUs with private agencies or private practitioners so that the hospital's service delivery commitments and quality standards as a whole is well maintained
- It allows for raising funds through donations and user fees.

The danger is that often the Rogi Kalyan Samiti gets equated with only one-fourth of these objectives. If user fees are used as a cost recovery mechanism, then it would invariably lead to considerable degrees of exclusion of the poor. It often also leads to irrational utilisation patterns – like more use of CT scans or other diagnostics that can bring in money.

The other concern is that expenditure which state and central governments have to be committed to making, in the form of adequate drugs, hiring of staff etc., may be passed on to the Hospital Development Committees to be borne out of user fees in the name of flexibility. This would undermine the over all goals of the NRHM of increasing public spending on health care and of financial protection for the poor.

"The other concern is that expenditure which state and central governments have to be committed to making, in the form of adequate drugs, hiring of staff etc., may be passed on to the Hospital Development Committees to be borne out of user fees in the name of flexibility."

The RKS nonetheless needs to control a small but flexible fund available for a number of local necessities which would be impossible to get through central sanctions. The NRHM principle of providing an untied fund is helping substantially in increasing this space for flexible planning and taking the pressure off the use of user fees for cost recovery.

There are also concerns about public participation, but these would be dealt with in a later module.

Thus while these cautions are to be kept in mind, the opportunities the RKS presents are considerable and even now they have been explored very little. Where it is used as a tool of promoting accountability and of better financial management, it could substantially assist the whole district planning process.

Multi-skilling for Closing Specialist Gaps

Getting the correct skill-mix at each level of CHC is another major bottleneck. Having defined a minimum package of services at the CHC as being essential to meet public health goals, one now needs to a put

in place a road map, by which the desirable mix of skills needed for delivering such a package of services would become a reality.

One of the important decisions to reach this mix is to devise a number of short term courses that can train MBBS doctors in some life saving skills and some basics of specialist skills – which were once part of the expected outputs of the MBBS course but in recent times got delegated to specialists. This de-skilling is most obvious in the field of surgery, but even in areas like mental health, eye care and child health such de-skilling is a problem.

The approach to multi-skilling for specialist skills is described in some detail in modules 2 and 5.

Private Sector Partnerships

- In some states, though specialists are not available at the block level in the public health sector, they are available in the private sector. Where such a situation exists there is need to ensure that their services are harnessed to help the CHC reach its goals or ensure that such referral services as the CHC should have provided are made accessible to the poor at block level.
- There are two choices to doing this:
  a. One is to contract-in specialists from the private sector on a per case basis, with or without monthly or annual retainer fees. Here the specialist comes to the government facility to provide his or her services.
  b. The other is to enter into contracts with them so that they would see patients referred by the public system at fixed rates and agreed upon quality of care. For seeing poor patients they would be reimbursed by the government. Here the patient is sent to the private nursing home or clinic to get the specialists services
- CHC committees can be empowered to make such contracts, with state and district level agencies monitoring the adherence to the terms of the contract.
- The key issues of concern are to ensure that such arrangements are prioritised for areas where there is no public facility thus expanding the provision of services – and not where they would merely lead to a shift in practice from the public provider to the private provider. The aim should also be to increase the net investment in public health care and not to transfer public resources to private management. Attention also needs to be focused on mechanisms to draw up a fair contract and ensure adherence to it.
- Private sector partnerships as a management strategy are another issue and discussed in a later module.

WHAT OTHER SUPPLEMENTARY STRATEGIES MAY BE NEEDED AT STATE LEVEL?

On adequacy of CHCs

- Blocks that do not have a CHC should be sanctioned a CHC on priority basis. There are very few blocks without a CHC but even then this small gap needs to be filled, so that subsequent planning may take all CHCs into account.
- The total number of CHCs should be as per population norms and not by administrative blocks. As an immediate measure, intermediate facilities, which we call upgraded PHCs, may be considered. Each upgraded PHC may be equipped with 6-10 beds, an ambulance and more medical officers to achieve a 24 hour medical coverage. They differ from CHCs in that they do not aim for major surgical capability, and from PHCs in that they are 24 hour services and provide hospitalisation. They also have a vehicle to transport those who need surgery to the CHC. Of course this largely resembles the current IPHS standards for all PHCs. Over time, even these should become full-fledged CHCs.

The Role of the Block Medical Officer

There is much to be gained from developing the Block Medical Officer (BMO)as a trained manager of public health and as administrator of the CHC. Where public health has been separated from the CHC's functioning, as in the case of Andhra Pradesh, there are considerable problems of coordination between the two. The CHC when separated out from its functions in primary health care becomes a centre of curative care. Without referral support and active leadership, primary health care loses credibility and does very poorly. The BMO could be usefully made a designated post, equivalent to the deputy CHMO. It should be the entrance point to an administrative cadre. BMOs would be required to undergo training on public health.

Review Questions

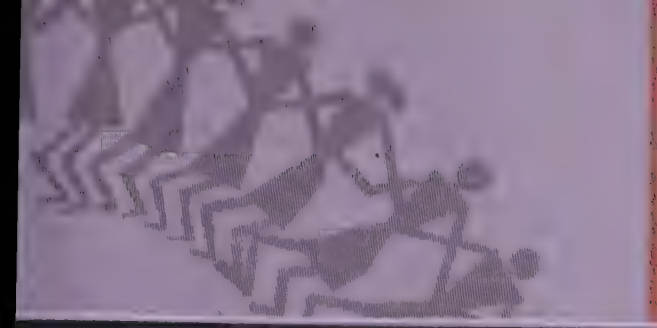
What maternity services are expected from CHCs and FRUs and CEmONC centres each?
What are the main differences between a PHC and CHC in terms of expected services? Between a CHC and a District Hospital?
List the specific features of the NRHM that are likely to have a beneficial effect on the functioning of CHCs
What are the main bottlenecks for the CHC to deliver all the services expected from it? Give some strategies to overcome each.

Application Questions

1. How important is it for CHCs to be well functioning and why?
2. Of all the strategies mentioned to overcome the bottlenecks, which do you think apply most to your district and why?
3. Look up an example of public private partnerships in service delivery at block level and analyse for costs and benefits. (you can use case studies available on the internet or in a journal of public health)

Project Assignment

1. Visit a poorly functioning and a well functioning CHC in your district. Analyse reasons for level of functioning. Suggest corrective measures for the deficiencies and gaps.
2. Collect district level data about the number of CHCs available and reports on their quality if any.
   According to population norms and IPHS norms, make district level recommendations to make all of them fully functional, using the NRHM strategy of upgradation of 2 CHCs per year.



Lesson SEVEN

Support and Management Systems

In this lesson we shall discuss:

- The support systems that are essential to make public health facilities functional
- The institutions and mechanisms that have been created for management of the public health system.

INTRODUCTION

The effectiveness of the public health facilities – the Sub-centre, the PHC, the CHC, the district hospital and the tertiary care hospital – is at the heart of a functional public health system. However these facilities themselves cannot be effective without a number of key support systems- all of which are essential and need to be functioning optimally.

SUPPORT SYSTEMS

Below is the list of the main systems that are required to support the functioning of the public health facilities and implement its various programmes:

A. Management Information Systems (MIS): These are systems by which the management at each level learns about the state of the facilities so that it can take necessary steps to improve their functioning. In essence a health MIS defines the flow of information about programme functioning and the delivery of services from the periphery to the block head quarters and the district headquarters, and which levels information is to be aggregated, analysed and acted upon. From the district, information also flows to state and national management centres, to enable monitoring and management of these centres. There are three components that are central to the building of a MIS:

1. A definition of what data is to be collected, by whom and from what source
2. The channels by which this information flows up (computerisation considerably expedites this flow of information) and
3. Most importantly, how this information is analysed and used to trigger management action

All health systems have MIS in place. Always. The issue is how well designed and functional each component of this is and how reliable is the data that is fed in. In most states the systems are in need of considerable overhaul and sometimes re-design. This will be discussed in detail in modules 10 and 11.

B. Disease Surveillance Systems: These are systems that operate to know what the profile of diseases is – both communicable and non communicable - and convey this information to the facilities and to the health system managers so that they are able to take corresponding technical and management decisions. These will also be discussed in module 9.

C. Behaviour Change Communication: Much of health rests upon life styles and behaviour patterns. The promotion of health, as different from prevention of disease and cure of disease, also requires considerable attention to change of behaviours. There needs to be a system in place for assessing

behaviours, their relationship to health, determinants of such behaviours as well as promoting behaviour change through appropriate communication. This also requires an institutional structure along with capacity building, monitoring and evaluation mechanisms to carry out these tasks. All of these together define a sub-system that has to be well integrated with the public health system as a whole. In many districts what happens under this head is lot of publicity relating the government programmes and some transfer of key messages. The effort to actually have a plan of ensuring changes in behaviour is far from complete and is discussed in greater detail in module 5.

D. Referral and Transport Systems: A good referral and transport system links the various facilities at different levels and weaves them together into a single system. Thus a PHC doctor and the patient he sees can access the consultation and diagnostics services of a tertiary care level facility. If there is a treatment requirement which is beyond the PHC's or CHC's capacity, it would be able to refer the patient to the most appropriate place. In practice, in most states referral and transport systems and the communication link that they need are very weak. Mechanisms of achieving this are discussed in module 2 in part and again in module 16. Transport systems are also needed for transport of supplies and human-power but these are discussed along with the management of materials in module 11.

E. Human Resource Management (Workforce Management): There have to be systems in place for recruiting staff in a fair and transparent manner, ensuring that they have adequate conditions of service (i.e. salaries, promotions, transfers, and leave, pensions, loans, medical care, grievance redressal mechanisms etc.). In many states salaries have stagnated, promotions have been delayed by over ten years, transfers tend to be arbitrary and unfair and there are many other workforce issues that lead to very poor workforce motivation and morale. District level management needs to address these issues in a competent and fair manner, and needs to be empowered so that it can address these issues as well as undertake fair disciplinary action in case of negligence and be innovative in rewarding good performance.

F. Human Resource Development (especially Training): Almost all the staff that makes the system functional is technical staff. There is a constant need to refresh and strengthen staff members' existing skills and update these skills to match changing needs as well as developments in techniques and technology. Such a system also needs to be linked to a policy and a strategy that envisages a career plan for each employee. Along with the systems for workforce management discussed above, human resource development systems ensure that every facility has the human resources it needs with the necessary skills and motivation to make the system functional. This will also be discussed in module 5.

G. **Infrastructure Development and Maintenance Systems**: The public health system in India has in place already an enormous amount of infrastructure, but still needs an even greater amount of infrastructure to be put in place. This will then need to be maintained, and after it has aged, will need to be replaced. In most states it is the Public Works Department or the Rural Engineering Services that undertakes the development of infrastructure and many of these institutions are themselves in need of reform. States like Tamil Nadu and Andhra Pradesh have been able to set up para-statal institutions - corporations - that perform this function efficiently. In other states local communities and hospital development committees have been entrusted with this task and this also works effectively. This is also discussed in module 11.

H. **Equipment Procurement and Maintenance**: The public health system requires a large amount of technically advanced equipment. There have to be systems in place for deciding what equipment is needed, for procuring this equipment, maintaining this equipment in a functional condition and attending to breakdowns in a timely manner. In most states which have set up separate corporations for supplies procurement, these institutions are entrusted with at least part of the equipment purchase. Minor equipment like BP apparatus or thermometers are treated like other supplies and procured and distributed like supplies.(discussed in module 11)

I. **Drugs and Supplies Procurement and Logistics Systems**: Systems are needed to procure good quality drugs and supplies and ensure that they are available to the facilities in adequate amounts without any interruption. In many states a fixed quantity of supplies are procured once or twice a year and then distributed in fixed kits or fixed amounts to all the health facilities. This leads to a situation where well-functioning facilities run out of drugs, face problems in getting refills and lose clientele. On the other hand underutilised and poorly functional facilities get more drugs than they can use and end up wasting them. Often irrational or poor quality drugs are bought and at higher rates than would be available on the market. This thus becomes a major source of corruption of the whole department in addition to being a major cause of poor functioning of all facilities. Moreover drug budgets also do not rise in sync with increased utilisation. There is no scientific system currently in place for planning drug budgets. But these issues are not difficult to solve. One internationally recognised benchmark for management of procurement and distribution of drugs is the Tamil Nadu Medical Services Corporation (TNMSC). The systems built up by the TNMSC allow considerable decentralisation in procuring and distributing supplies, yet gain the advantages of cheaper costs and better monitoring of quality that comes with efficient centralisation. Most of the problems related to drug procurement, drug quality and drug distribution have been successfully managed by this system. This is discussed in greater detail in module 11.

J. **Financial Management Systems**: The flow of funds needs to be planned out, and funds need to be distributed on time to different points of expenditure, accounted for and audited. This requires a high degree of efficient and technically competent management. Unfortunately, this is not even recognised as a technically demanding area, and key decision makers try to make do with common

sense and come to grief. Cash flow is most often interrupted because the accounts for earlier funds have not been submitted. Sometimes the plan has been made without taking into account time delays that occur due to processing of request for release of funds.

Another major aspect of financial management is to see the cash flow as a tool of health planning and monitoring and guiding programme implementation. This is even more technically demanding and again an area where mere common sense is a poor guide. Very often programmes get seriously interrupted because cash flow is interrupted.

K. Public Financing with Private Provisioning Systems: One special area of financial management is when financial management becomes a key form of public health delivery. In such instances the provision of care is in the private sector. The responsibility of the government is to reimburse the patient or the health facility for a part or all of the costs incurred in treating the patient. Today, this is most commonly a facility that government employees use when they are availing of care that is certified as not being available in the public health facilities (through the CGHS etc). Also there is a provision for a few patients to avail of such reimbursement facilities under special recommendations of the Prime Minister or Chief Ministers of the state for certain categories of illness. However, with the opening up of programmes like Janani Suraksha Yojana to private providers and many other schemes for public private partnership, this area of public health management is likely to grow immensely.

Other than financial management, such public financing and private provisioning requires skills at formulation and negotiation of contracts, mechanisms of monitoring and regulation of costs and quality of care and systems of ensuring access to the poor. Thus if this area of activity grows, a new form of health management which is currently not present, will have to come into being. It would be not just a health manager but an entire support system of management, monitoring, negotiation, regulation that would be needed.

L. Health Insurance, Risk Pooling and other Financial Protection strategies:
Another growing area of public health systems is the provision of health insurance, the management of risk pooling strategies and other forms of social security to protect people from the high and often unexpected costs of health care.

Even if insurance companies were to manage the whole programme it is only a case of shifting the site of management. However, the issues of management of support systems, as discussed above, will remain. In practice many of the schemes being considered are not conventional commercially viable insurance programmes but different forms of social security and community based insurance where the government may have substantial management roles. Currently almost no state has a major government-managed insurance scheme. If this happens this would be another major sub-system that would have to be put in place.

M. **Regulation of the Private Sector:** Another area of programme management is the area of regulation of the private sector in health. The management of hotel sanitation and hygiene, prevention of food adulteration, regulation of private pharmacies and drug licensing, drug information and distribution comes under the existing directorates of food and drug control authorities. In addition many states have passed Private Medical or Clinical Establishments Acts. However in most states the rules and regulations have not been framed or there are court orders staying its implementation. Nevertheless, sooner rather than later, all the states would have to develop systems of regulation of the private sector that ensures that the private clinics maintain minimum quality of care, charge reasonable fees and adhere to ethical and rational practice.

N. **Health Professional Education and Human Resource Planning:** One major function of the public health system is the creation of qualified human resource for various aspects of preventive, promotive and curative health care. The leading institutions in this are of course the medical colleges that produce general (or 'basic') doctors and specialists. Other than this are institutions that produce nurses, male and female multipurpose health workers, pharmacists, laboratory technicians, other specialised technicians for operating X-rays and other radiological equipment, assistants in eye care, in counseling and psychiatric care etc. Further, a number of institutions are now skilling and certifying people with management skills for hospital administration and public health management.

O. **Strategic Planning and Policy Development:** This is really the role of governance. This is primarily the task of the elected representatives of the people: the ministers, with their secretaries. At the district level it is the task of the heads of elected Panchayats. But since this is a technically demanding domain, those in governance at the district level may need to be assisted by the directorates of health. In practice, directorates are so overloaded with routine work that the collection and analysis of information to aid planning and policy formulation and the generation of ideas and options for planning require a separate system.

Most states and the centre have a number of institutions charged with this responsibility. Such a unit can take a comprehensive view of different programmes, ensure convergence and coordination wherever needed, and develop policy drafts and implementation guidelines. This has to be done along with the sections involved in this work on a day to day basis. However there are a set of skills and information required for this work and the creation of an institutional or organisational mechanism for this has been found useful. In many states though such units have been created, they have not been sustained and are now not very functional. (This is discussed further in module 14). Other states have got very active strategic planning institutions in place, for example, Andhra Pradesh has the Strategy, Performance and Innovations Unit (SPIU) and Chhattisgarh has the State Health Resource Centre (SHRC).

P. **Health Systems Research:** Health Systems Management needs, most immediately, health systems research. It requires inputs from research in public health – both epidemiological and qualitative. It also needs to support a programme of basic research in understanding of disease and all of its medical and its social determinants. Most states have no policy in the area of research and development. This is because it is often believed that research inputs are not needed, and 'only action is required'. But even action and its outcomes need to be systematically measured. Moreover research introduces a culture of critical reflection and analysis, of imagination, of being able to pose different questions to old problems, of being able to construct tools for understanding, of being able to generalise one's experience to construct theories and of being able to use theory to construct practice. Such an 'academic' culture once created, benefits not only those involved in research work but the general attitudes of the system. On one hand the health system bemoans lack of imagination, and lack of capacity to plan. On the other hand it runs down academics as irrelevant. The caveat is that it should be 'good' academics. What health systems need are systems of ensuring not only that research happens, but that it is of good quality and that the capacity to do good research and use research inputs is built up. There should be a balance between questions of immediate relevance and those of longer term or more fundamental nature. If basic research is totally restricted within a research system, then applied research would also suffer.

The level and type of research at the national level, the state level and the district level would vary. The principle is that all three levels require research inputs though its relevance is least understood as we go down the pyramid.

Support Systems to Public Health Facilities:

1. Management Information Systems (MIS)
2. Disease Surveillance Systems
3. Behaviour Change Communication
4. Referral and Transport Systems
5. Human Resource Management (Workforce Management)
6. Human Resource Development (especially Training)
7. Infrastructure Development and Maintenance Systems
8. Equipment Procurement and Maintenance
9. Drugs and Supplies Procurement and Logistics Systems
10. Financial Management Systems
11. Public Financing with Private Provisioning Systems
12. Health Insurance, Risk Pooling and other Financial Protection strategies
13. Regulation of the Private Sector
14. Health Professional Education and Human Resource Planning
15. Strategic Planning and Policy Development
16. Health Systems Research

THE STRUCTURE AND FUNCTION OF PUBLIC HEALTH SYSTEMS MANAGEMENT

The coordination and management of all these functions requires an effective management system to be in place. Management functions exist at three levels- at the state level, at the district level and at the block level.

Management functions at state and district level relate to:

a) Supervision of the health care facilities
b) Management of specific health programmes
c) Management of all the support functions outlined above

The Management Structure at the State Level

At the state level the management functions are organised in different ways. The main District Health Management team report to a Director or Directors at the state level who report to a Commissioner of Health who reports to the Secretary of Health. There are also a number of health programmes each of which have joint director in charge who reports to a director who reports to the Commissioner or directly to the Secretary. One such organisational structure is given in Annexure 2. In each state the exact number of Directors, the number of Joint Directors and Deputy Directors, the number of Secretaries and Principal Secretaries looking after different aspects differs. Also the chain of command and the degree of autonomy of different components differs.

Para- Statal Bodies

In addition there have been one or more para-statal bodies created at the state and district level. A para-statal body usually refers to a registered society. Such a registered society has a governing body and an executive committee which may or may not have non governmental representatives. Such a body is legally an independent and autonomous society. However since most of the funds are from the government, government rules apply to it. Also since most of the key decision makers, if not all, are from the government, they are subject to the hierarchy of decision making within the government and hence they are answerable to the legislature and most government norms of service. The advantages of such an arrangement lie in:

a) Easier decision-making on day-to-day management.
b) More participative, collective and transparent decision making.
c) Better coordination with other related sectors.
d) Ease of recruitment of staff especially consultants, since they are not permanent employees. Permanent employees are recruited through the state staff selection commission which can be a cumbersome and time consuming process.
e) Easier financial transaction since the large number of clearances required when money is drawn from the treasury is reduced.
f) Transparency – especially to international funding agencies – to be able to track that the money is used efficiently for the purposes stated and has not been diverted to other purposes.

The actual experience of these para-statal bodies is mixed. In some states in some such bodies all or some of these advantages have been realised. Whereas there are also bodies where none of these advantages have been realised. Still, since a considerable part of programme budgets (as opposed to staff salaries and basic drugs and equipment costs) flow through these societies, their organisation and functioning has a major impact on the health care services. Recruited and working under these bodies are various programme management units.

Examples of such bodies are the State Health Society, State Health Mission, State AIDS Control Society, State RCH Society, State Malaria Control Society, State Committee of Voluntary Associations (SCOVA).

Because of the problems of multiplicity of these bodies there have also been steps to merge all these bodies at the state level into a state health society, governed by a state Health Mission with all the earlier bodies acting as sub-committees of this unified organisation.

There are another set of para-statal bodies whose purpose is to devolve certain management functions to autonomous organisations for more efficient and transparent implementation. Thus for example Tamil Nadu has set up a Tamil Nadu Medical Services Corporation whose sole purpose is to undertake all procurement and distribution of drugs and supplies as well as purchase of equipment and some part of infrastructure development. Thus, the rest of the Directorate is freed from the pressures and burdens of these tasks and can concentrate on programme management while those better qualified in management of purchases and logistics can be applied to these tasks.

District Level Health Management

Again the pattern varies from state to state. In most states, the peripheral health facilities (Sub-centre, PHC and CHC) and all the national programmes are under one district officer called the Chief Medical Officer (CMO) while the district hospital is under another officer, the Civil Surgeon. The names of these posts often vary. Sometimes the CHC is also under the Civil Surgeon along with the district hospital- and some time it is with the CMO. The CMO is assisted by three of four programme officers who are usually clinicians holding these posts as additional administrative responsibilities.

The district health management also has para-statal bodies, and it is usually the District Collector who is the chairperson or the senior executive and the CMO is its secretary. The district Panchayat president usually has a role and some powers in these bodies, but the exact roles and delegation of powers to these bodies itself and to the District Collector and the district Panchayat head is different in different states.

The current policy is to merge all district level bodies into a District Health Society with the various already existing district level societies of specific programmes continuing to function as sub-committees in the same.

The advantages that are expected are as stated for the state-level committees. In practice the main change that occurs at the district level is that the District Collector is empowered to play a greater role in the supervision and functioning of the health sector.

The issues relating to district health management are dealt with in module 11. The issues relate to devolution of powers, the participation of Panchayats, the professional nature of management and the effectiveness of district level planning.

Block Level Health Management

There are very poorly developed systems of block level management in most states. One of the medical officers is in charge – and is known as the Block Medical Officer. Often even this is an informal or ad hoc arrangement. No experienced administrator or person with training in administrative work or finance is available and in the absence of these structures block level health management is often an ad hoc issue by issue affair.

One of the important elements of the NRHM is to create a block level health management structure, and to strengthen district and state level health management.

Review Questions

1. What is the importance of having a good MIS? What are its essential components?
2. List all the financial management systems required to make the NRHM successful along with their main functions.

Application Questions

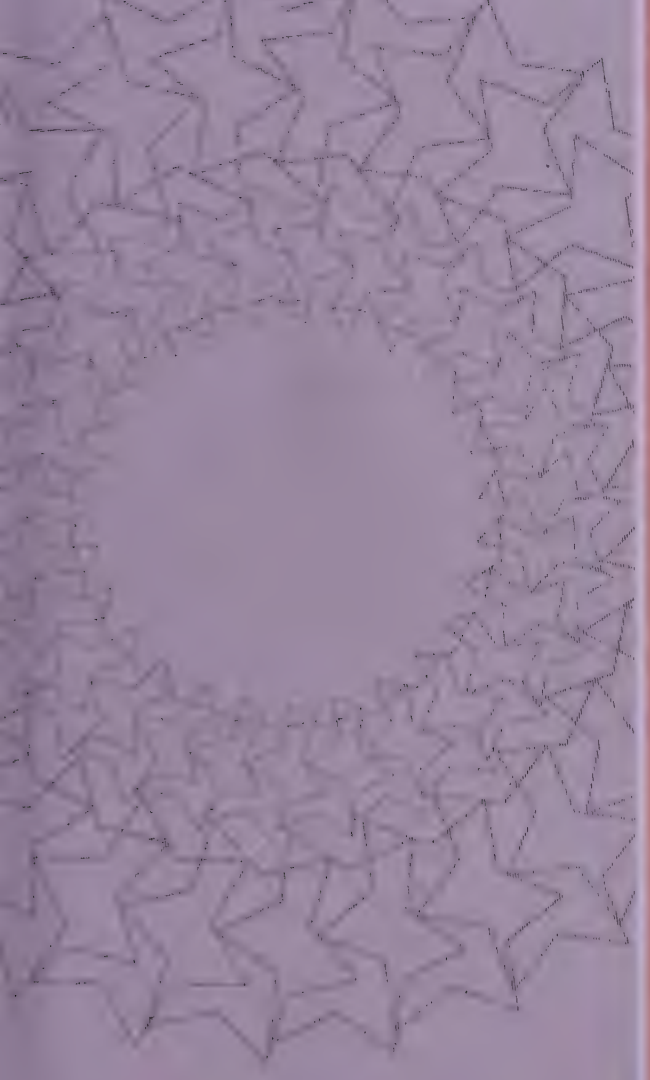
1. What is your opinion on the relevance of research for health planning and management? What constitutes 'good research' in your opinion? Why do you think there is a general negative view of academic work and research amongst the people involved in day to day management of health programmes and services?
2. Management has been rather simplistically described as the management of the three M's- Men (human resource), Material and Money. In the list of support functions given above most of the items would fall into one or more of these categories. But some would not. Try organising them under the 3 M categories and find out which does not fall within the definition.

Project Assignment

1. Of the entire list of support systems provided in this lesson, describe which ones exist in your state and district. Based on discussion with those working in these areas and those working in facilities using these support systems, rate each of these according to their functioning.
2. Describe diagrammatically the state level, district level and block level management structure that exists in your area.
3. Rate their present level of functioning and suggest a few immediate steps for improvement at each level.

Lesson EIGHT

Mainstreaming AYUSH



- The broad structure of AYUSH facilities in the public health system
- The concept of mainstreaming AYUSH facilities
- The guidelines for mainstreaming AYUSH
- The potential of AYUSH for the public health system

INTRODUCTION

AYUSH is a Sanskrit word meaning "long life" used in the traditional greetings of *ayushman bhava* implying best wishes for good health.

AYUSH is also an acronym for Ayurveda, Yoga, Unani, Siddha and Homeopathy – which are the various indigenous and alternative forms of the practice of medicine – alternative that is to modern medicine. Of these, three systems are indigenous – ayurveda, yoga and siddha. Unani is of Persian origin, itself further tracing back its origin to Ancient Greece as the name implies. But so much of what is now practiced as Unani is developed in India that it is well recognised as an indigenous system. Even in ayurveda and siddha there are many cross cultural borrowings and there is much in common between these systems and European and Persian systems of the past. For that matter what is known as modern medicine today (or called allopathy) also has borrowed considerably from ayurveda and other systems. Homeopathy is of European origin of the late nineteenth century.

The practice of all of these systems enjoys considerable popular support. These systems also have a strong emphasis on promotive health and management of life styles. In addition to these systems of medicine at the village level there are many folk practitioners and local traditions and knowledge that also contribute significantly.

The Departments of Health and Family Welfare in the states and the centre have a major role in the provision of AYUSH services to the people. This was earlier called the Department (or Directorate) of Indian Systems of Medicine and Homeopathy (DISM&H). AYUSH services are thus an important part of the public health system.

THE STRUCTURE OF AYUSH SERVICES

We note that the public health facilties in AYUSH are fairly extensive. Thus the total number of ayurveda dispensaries – most of which have at least one ayurveda trained medical officer is 15,193. If we add all the systems together there are 22,550 dispensaries or at least that many doctors of AYUSH in the public health system which is about equal to the number of doctors in PHCs. (There are 23,109 PHCs in which there are 21,974 doctors.) Most of these dispensaries also have one or two health workers in place. A PHC of course has many more health workers.

Table 8.1 : Summary of Medical Care facilities under Indian System of Medicine and Homoeopathy by Management Status in India - 2005

Sr. No.	MANAG-EMENT	Ayurveda		Unani		Siddha		Yoga		Naturopathy		Homoeopathy	
		Dispen-saries	Hospital	Dispen-saries	Hospital	Dispen-saries	Hospital	Dispen-saries	Hospital	Dispen-saries	Hospital	Dispen-saries	Hospital
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)
1	STATE GOVT./ U.T./ ADMIN.	13984	554	1094	38	437	270	28	4	12	11	4567	80
2	LOCAL BODIES	966	16	43	0	0	0	0	0	8	0	774	2
3	OTHERS	12	158	1	24	0	4	40	3	32	10	61	135
	SUB-TOTAL (1 TO 3)	**14962**	**728**	**1138**	**62**	**437**	**274**	**68**	**7**	**52**	**21**	**5402**	**217**
4	CENTRAL MINISTRIES	225	1	10	0	5	0	3	0	3	0	192	0
8	CENTRAL RESEARCH COUNCIL	6	24	5	12	2	2	0	0	0	0	40	6
	TOTAL	**15193**	**753**	**1153**	**74**	**444**	**276**	**71**	**7**	**55**	**21**	**5634**	**223**

SOURCE : P&E Cell, D/o AYUSH, Ministry of Health & Family Welfare

The number of hospitals and the number of beds are however much less than what is available in the mainstream of modern medicine facilities in public health. The AYUSH systems also have sections dealing with health education, and with drug procurement and distribution.

The AYUSH systems also have a large number of practitioners in the private sector – and their numbers outnumbers by far the numbers in the public health system. The figures of practitioners of AYUSH are given in the following table:

Table 8.2. Registered Practitioners of the AYUSH systems.

MANAGEMENT	Ayurveda	Unani	Siddha	Yoga	Naturopathy	Homoeopathy
Registered AYUSH Doctors	438721	43578	17560		541	217460

SOURCE : P&E Cell, D/o AYUSH, Ministry of Health & Family Welfare

PROBLEMS OF THE AYUSH SECTOR IN THE PUBLIC HEALTH SYSTEM

Though such a large manpower and infrastructure has been created – there has also been considerable neglect in its management and in its utilisation. This is a problem even in the planning stage. Most district plans, for example, would not have any section on the AYUSH sector at all. Many State Programme Implementation Plans and Sector-Wide Programmes also do not have mention of the AYUSH sector. Partly this arises from a mind-set where there is a patronising tolerance shown to this sector, which is not perceived as having much to contribute to health goals. Partly this is because the command structure of this sector has been segregated out. Sometimes there is even a separate secretary in place. At the district level there is a district officer who may not even be on the district health society and whose work seldom gets reviewed in the district reviews.

Another key issue is the need for an objective evaluation of the contribution that these systems make to the goals of public health. The potential to make a contribution is recognised. But is it in making such a contribution on the ground? Had this system not been there in the public health system what would have been the set back from achieving the goals we have set?

If goals are described only in terms of reduction of maternal and infant mortality the contribution is uncertain. If one the other hand the goals are understood as the provision of "essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families.....and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination" then the role of AYUSH becomes clearer.

The AYUSH components of the health care system face a number of problems in delivering health care. Some of these are:

a) Many dispensaries have very poor utilisation and there is no effort invested in improving their functioning and utilisation.

b) The practice of AYUSH is often overshadowed by cross –practice a term used to refer to the fact that many of the practitioners are actually practicing modern medicine much of the time. This too acts as a barrier to make adequate use of AYUSH. On the other hand it is argued – that if AYUSH remedies are not appropriate for a particular situation the doctor should have the choice to switch to the use of modern medicine remedies.
c) The practice of AYUSH is also over taken by the "pill for every ill culture." There is considerable purchase and prescription of commercial preparations. This leads to a consumption pattern driven by pharmaceutical firms of drugs that are costlier but not necessarily more effective. There is very poor standardisation, no standard treatment protocols in place and not even a list of essential drugs at the state levels. The uses of compounded medicines and local herbal remedies and preparations which are cost effective have come down.
d) There is a major problem of lack of adequate drug budgets and lack of drugs in the dispensaries. AYUSH drugs have become commercialised and are much costlier now.
e) The health promotive role of AYUSH, so strong in its theory, has lost its importance in the way it is often practiced.
f) The dispensaries and hospitals of AYUSH are often located in peripheral areas and separated from the main hospitals and clinics of modern medicine. Even where modern medicine is the main choice for many ailments there are conditions for which they would like AYUSH remedies but because of the isolation of AYUSH facilities they are unable to access them.
g) There is little investment in promoting the use of AYUSH systems and local herbal traditions for those remedies that have been found effective.

There are larger problems of these systems also. No doubt many of these remedies are useful. But how effective are they? Have they been tested and validated? Is there information available on which drugs are validated and which are not? Are the drugs and syrup formulations standardised?

These problems also affect the practice of modern medicine. Over 90% of drugs sold in a pharmacist shop could be irrational or unscientific too. To rationalise the use of drugs most states have drawn up essential drug lists. There are drug testing laboratories established. There is a need for similar rationalisation in AYUSH remedies and the need to collect sufficient data to do this.

MAINSTREAMING AYUSH

The term 'mainstreaming AYUSH' has many interpretations.

1. **Using the AYUSH Human Resource for other National Programmes:** One simple interpretation has been to use the large human resource available in this sector for core public health activities including midwifery, immunisation, malaria control etc. This could be objected to as subverting them from practice of their systems to the practice of modern medicine. But in practice such AYUSH staff is

very ready, willing and eager to join in. Often they are annoyed that they are not treated as equals and are not allowed to participate even in important programmes. Also, most practitioners are willing to practice modern medicine without any misgivings. This is less in homeopathy and unani practitioners but almost the rule in ayurveda practitioners who form the majority of this cadre. It is often the mere professional reluctance of the medical officers which makes it difficult to use their services.

2. **AYUSH doctors as PHC medical officers:** Another mainstream use of the AYUSH has been to recruit doctors with AYUSH qualification to fill up vacancies of medical officers on an ad hoc or contractual basis against vacancies in primary health centres where it has not been possible to get medical doctors. This is true for almost all remote areas. The argument is that theirs is also a four year course in which they are also taught basics of diagnostics and therapeutics of modern medicine. Also, subjects like anatomy, physiology etc. are taught in a similar manner. Thus in a difficult district like Dantewada in Chhattisgarh state the majority of medical officers in PHCs are AYUSH qualified doctors. There is now a suggestion to make all PHCs into two doctor PHCs with one of the doctors being an AYUSH practitioner.

3. **Sharing Infrastructure:** Like with the mainstream health facilities, AYUSH facilities also face the problem of, on one hand, not having enough infrastructure and on the other hand having considerable infrastructure that goes under-utilised. It has been estimated that if both systems share their infrastructure – both would benefit. There would be more facilities with infrastructure and more staff available per facility.

4. **Setting up ISM& H wings in district "allopathic" facilities outdoor and indoor:** States have come forward to have an outpatient clinic and some indoor beds for an AYUSH practitioner in all CHCs and in all district hospitals. There is now a central government scheme available which provides Rs. 35 lakhs per district hospital for initiating an AYUSH facility – both inpatient and outpatient into the district hospital. One or two systems AYUSH can function from this facility. Such a scheme has been extended to all CHCs also in some states. There is also a suggestion as noted earlier to have an AYUSH medical officer in every PHC in addition to one doctor from the modern medicine stream. This scheme is one of the most appropriate uses of the term mainstreaming AYUSH. Patients would now really have a choice of consulting either or both streams of medical practice.

5. **Specialised therapy centres in allopathic hospitals and medical college hospitals:** There is now considerable demand for some of the more expensive and elaborate AYUSH remedies. These are the *panchkarma* therapy, the *kshar sutra* therapy, regimental (*liaj bil tadbeer*) therapy and a yoga and naturopathy centre. There is now a scheme in place wherein these specialised therapies can be introduced in hospitals of modern medicine including medical college hospitals. Each of these specialised therapies have been sanctioned two postgraduates in AYUSH, 4 paramedicals, 1 pharmacist and 1 Multi Purpose Worker.

GENERAL ISSUES

In addition to the above mainstreaming measures there are some routine steps needed to strengthen the functioning of the AYUSH system:

a) **Better Monitoring and Supervision of AYUSH facilities:** Details of out patient and in patient attendance should be collected and analysed at least monthly.

b) **An Essential Drug List,** stating acceptable formulations should be adopted by careful consultations and the procurement of drugs should be restricted to this list. The preparation of **standard treatment guidelines** should be initiated and disseminated.

c) **Procurement and Distribution of Drugs:** These should follow the same norms as for allopathic drugs. However there needs to be a conscious emphasis on use of local resources so as to stimulate local markets in the preparation and processing of medicinal plants.

d) **Training:** There are two systems of training that need to be urgently put in place. First is training ayush practitioners who have been given roles as general duty medical officers and in national programmes to understand these roles adequately. This may require as much as the equivalent of one month training invested every year for three to five years for this gap to be covered. And this should go along with the preparation of standard treatment protocols meant for their use. This protocol would have to be worked out carefully and would have a level slightly above the level of care a trained paramedical would provide – but not the same as what an MBBS doctor would provide.

   Second aspect of training, is in the practice of AYUSH itself. Opportunities for ayush practitioners to meet, to share information and experiences, to study their own work are extremely few. There are almost no workshops, no meetings and no continuing education efforts organised. These would also be the minimum requirements of a training plan.

e) **Strengthening AYUSH Management:** Many ayush graduates are now taking up training in public health management, in epidemiology and in related health administrative roles. There is need to strengthen the management of AYUSH facilities and also draw on its capacities to strengthen the management of health in the district and state level.

Review Questions

a) What are the various systems of medicine that fall under the category of ISMH or AYUSH?
b) What are the programmes that can be incorporated in a district plan under the heading of mainstreaming AYUSH?
c) What are the problems of drugs and supplies in this sector?

Application Questions

a) There is a marked difference in the salary remuneration offered to doctors from these two streams for the same task? Why should this be so? Should this be so?
b) What would be the problems of evolving an essential drug list or a standard treatment protocol in this sub-sector?

Project Work

a) In your district what are the facilities available under AYUSH? How many staff do each have? What is the attendance in each of these facilities?
b) What are the issues of infrastructure and supplies in these facilities?
c) Get a copy of the district health plan and search in it for the section on AYUSH. If it is not there prepare a draft for inclusion in the plan. If it is there how would you like to modify it?

Lesson NINE

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NOTES

Annexure 1

Indian Public Health Standards For 24-Hour PHCs

(The note below is an extract from the document IPHS for 24 hours PHCs published by the National Rural Health Mission. The details of the infrastructure, building plan, the equipment and drugs needed for a PHC to provide an optimal quality of these services have been given in the document but this not been given below. This extract published below is only to highlight the services expected of a primary health centre. Similar IPHS standards have been published for the CHC as well. The services prescribed are given in the main lesson. The infrastructure, drugs and equipment lists of the CHC are also available in the published document. Similarly for the Health Sub-centre and the District Hospital also IPHS standards are being defined. All these documents can be accessed in full from the website of the National Rural Health Mission or the Public Health Resource Network. Or one could write to their offices).

In order to provide optimal level of quality health care, a set of standards are being recommended for Primary Health Centre to **be called Indian Public Health Standards (IPHS) for PHCs**. The nomenclature of a PHC varies from State to State that include a Block level PHCs (located at block HQ and covering about 100,000 population and with varying number of indoor beds) and additional PHCs/New PHCs covering a population of 20,000-30,000 etc. **The standards prescribed in this document are for a PHC covering 20,000 to 30,000 populations with 6 beds,** as all block level PHCs are ultimately going to be upgraded as Community Health Centres with 30 beds for providing specialised services. Setting standards is a dynamic process. Currently the IPHS for Primary Health Centres has been prepared keeping in view the resources available with respect to functional requirement for PHCs with minimum standards such as building manpower, instruments, and equipments, drugs and other facilities etc.

OBJECTIVES OF INDIAN PUBLIC HEALTH STANDARDS (IPHS) FOR PRIMARY HEALTH CENTRES

The overall objective of IPHS is to provide health care that is quality oriented and sensitive to the needs of the community. The objectives of IPHS for PHCs are:

- To provide comprehensive primary health care to the community through the Primary Health Centres.
- To achieve and maintain an acceptable standard of quality of care.
- To make the services more responsive and sensitive to the needs of the community.

Minimum Requirements (Assured Services) at the Primary Health Centre for meeting the IPHS

Assured services cover all the essential elements of preventive, promotive, curative and rehabilitative primary health care. This implies a wide range of services that include:

3.1. Medical care:

- **OPD services**: 4 hours in the morning and 2 hours in the afternoon /evening. Time schedule will vary from state to state. Minimum OPD attendance should be 40 patients per doctor per day.
- **24 hours emergency services**: appropriate management of injuries and accident, First Aid, Stabilisation of the condition of the patient before referral, Dog bite/snake bite/scorpion bite cases, and other emergency conditions
- **Referral services**
- **In-patient services** (6 beds)

3.2. Maternal and Child Health Care including family planning:

a) **Antenatal care:** Early registration, Minimum 3 antenatal checkups, minimum laboratory investigations; nutrition and health counseling, chemoprophylaxis for malaria in high risk pregnancies, appropriate referral to FRUs

b) **Intra-natal care:** (24-hour delivery services both normal and assisted)

- Promotion of institutional deliveries; conducting of normal deliveries
- Assisted vaginal deliveries including forceps / vacuum deliver whenever required Manual removal of placenta.
- Appropriate and prompt referral for cases needing specialist care with pre-referral management, and appropriate Management of Pregnancy Induced hypertension.

c) **Postnatal Care:**

- Ensure home visit by CHVs on day first, A minimum of 2 postpartum home visits, first within 48 hours of delivery, 2nd within 7 days through Sub-centre staff.
- **Ensure** -Initiation of early breast-feeding within half-hour of birth by CHVs/ ASHA.(Details in other chapter)
- Education on nutrition, hygiene, contraception, (Details in other chapter)

d) **Essential new born care:** (As per Guidelines of GOI on Essential new-born care)

e) **Care of the child:**

- Integrated Management of Neonatal and Childhood Illness (IMNCI)
- Promotion of exclusive breast-feeding for 6 months.
- Full Immunisation of all infants and children against vaccine preventable diseases as per guidelines of GOI.
- Vitamin A prophylaxis to the children as per guidelines.
- Prevention and control of childhood diseases, infections, etc.

f) **Family Planning**:
Promoting appropriate Family planning methods; Provision of contraceptives such as condoms, oral pills, emergency contraceptives, IUD insertions, organising for Permanent methods like Tubal ligation and vasectomy / NSV and provision of Follow up services to the eligible couples adopting permanent methods (Tubectomy/Vasectomy). Counseling and appropriate referral for couples having infertility.

.3 Medical Termination of Pregnancies using Manual Vacuum Aspiration (MVA) technique (Wherever trained personnel and facility exists) with Counseling and appropriate referral for safe abortion services (MTP) for those in need.

.4. Management of Reproductive Tract Infections / Sexually Transmitted Infections: Health education for prevention and treatment of RTI/ STI

.5. Nutrition Services (coordinated with ICDS):

- Diagnosis of and nutrition advice to malnourished children, pregnant women and others.
- Diagnosis and management of anaemia, and vitamin A deficiency.
- Coordination with ICDS.

.6 School Health: Regular check ups, appropriate treatment including deworming, referral and follow-ups

.7. Adolescent Health Care: Life style education, counseling, appropriate treatment.

.8. Promotion of Safe Drinking Water and Basic Sanitation

.9. Prevention and control of locally endemic diseases like malaria, Kalaazar, Japanese Encephalitis, etc.

.10. Disease Surveillance and Control of Epidemics:

- Alertness to detect unusual health events and take appropriate remedial measures Disinfection of water sources
- Testing of water quality using H2S- Strip Test (Bacteriological)
- Promotion of sanitation including use of toilets and appropriate garbage disposal.

.11. Collection and reporting of vital events

.12. Education about health/Behaviour Change Communication (BCC)

3.13. National Health Programmes

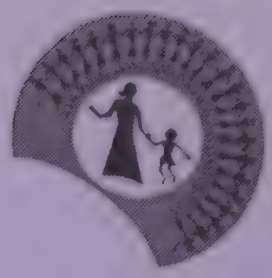
a. **Revised National Tuberculosis Control Programme (RNTCP):** All PHCs to function as DOTS Centres to deliver treatment as per RNTCP treatment guidelines through DOTS providers and treatment of common complications of TB and side effects of drugs, record and report on RNTCP activities as per guidelines. Sputum testing where designated as microscopy centre.

b. **Integrated Disease Surveillance Project (IDSP):**
- PHC will collect and analyse data from Sub-centre and will report information to district surveillance unit.
- Appropriate preparedness and first level action in out-break situations.
- Laboratory services for diagnosis of Malaria, Tuberculosis, Typhoid (Rapid Diagnostic test-Typhi Dot) and tests for detection of faecal contamination of water (Rapid test kit) and chlorination level.

c. **National Programme for Control of Blindness (NPCB):**
- Basic services: Diagnosis and treatment of common eye diseases
- Refraction Services
- Detection of cataract cases and referral for cataract surgery

National Vector Borne Disease Control Programme (NVBDCP):
- Diagnosis of Malaria cases, microscopic confirmation and treatment
- Cases of suspected JE and Dengue to be provided symptomatic treatment, hospitalisation and case management as per the protocols
- Complete treatment of microfilaria positive cases with DEC and participation and arrangement of Mass Drug Administration (MDA) along with management of side reactions, if any. Morbidity management of Lymphoedema cases.

National AIDS Control Programme:
- IEC activities to enhance awareness and preventive measures about STIs and HIV/AIDS, Prevention of Parents to Child Transmission (PPTCT) services.
- Organising School Health Education Programme
- Screening of persons practicing high-risk behaviour with one rapid test to be conducted at the PHC level and development of referral linkages with the nearest VCTC at the District Hospital level for confirmation of HIV status of those found positive at one test stage in the high prevalence states. Risk screening of antenatal mothers with one rapid test for HIV and to establish referral linkages with CHC or District Hospital for PPTCT services in the six high HIV prevalence states (Tamil Nadu, Andhra Pradesh, Maharashtra, Karnataka, Manipur and Nagaland) of India.
- Linkage with Microscopy Centre for HIV-TB coordination.
- Condom Promotion & distribution of condoms to the high risk groups.
- Help and guide patients with HIV/AIDS receiving ART with focus on adherence.



Referral Services

Appropriate and prompt referral of cases needing specialist care including stabilisation of patient, providing appropriate support for patient during transport and providing transport facilities either by PHC vehicle or other available referral transport

Training

- Health workers and traditional birth attendants
- Initial and periodic Training of paramedics in treatment of minor ailments
- Training of ASHAs
- Periodic training of Doctors through Continuing Medical Education, conferences, skill development training, etc. on emergency obstetric care
- Training of ANM and LHV in antenatal care and skilled birth attendance

Basic Laboratory Services

Essential Laboratory services including:

- Routine urine, stool and blood tests
- Bleeding time, clotting time,
- Diagnosis of RTI/ STDs with wet mounting, Grams stain, etc.
- Sputum testing for tuberculosis (if designated as a microscopy centre under RNTCP.)
- Blood smear examination for malarial parasite.
- Rapid tests for pregnancy / malaria
- RPR test for Syphilis/YAWS surveillance
- Rapid diagnostic tests for Typhoid (Typhi Dot)
- Rapid test kit for fecal contamination of water
- Estimation of chlorine level of water using ortho-toludine reagent

Monitoring and Supervision

- Monitoring and supervision of activities of Sub-centre through regular meetings / periodic visits, Monitoring of all National Health Programmes, and Monitoring activities of ASHAs
- MO should visit all Sub-centres at least once in a month and Health Assistants Male and LHV should visit Sub-centres once a week.

Mainstreaming of AYUSH services as per local people's preference

Rehabilitation: Disability prevention, early detection, intervention and referral

The PHCs would provide 24 hour delivery services and new born care, all seven days a week in order to increase the institutional deliveries which would help in reducing maternal mortality.

Selected Surgical Procedures

Vasectomy, tubectomy (including laparoscopic tubectomy), MTP, hydrocelectomy and cataract surgeries as a camp/fixed day approach have to be carried out in a PHC having facilities of O.T. During all these surgical procedures, universal precautions will be adopted to ensure infection prevention.

Record of Vital Events and Reporting

- Recording and reporting of Vital statistics including births and deaths.
- Maintenance of all the relevant records concerning services provided in PHC

Infrastructure

To achieve the above the IPHS lays down minimum standards for buildings, for the out patient department, for the waiting space, operation theatre (optional),labour room, laboratory and store, for the AYUSH doctor, for immunisation and family planning services, for office room, for residential accommodation, a dirty utility room, for a garden and boundary wall and gate. It also specifies that there should be electricity with generator back up, there should be adequate water supply, there should be a telephone. A model design layout is provided. *These can be easily downloaded from the NRHM website.*

Equipment and Furniture

The necessary equipment to deliver the assured services of the PHC should be available in adequate quantity and also be functional. Equipment maintenance should be given special attention. Periodic stock taking of equipment and preventive/ round the year maintenance will ensure proper functioning equipment. Back up should be made available wherever possible. A list of suggested equipments including furniture is given in the annexure of the IPHS list.

Drugs

All the essential drugs available in the Sub-centre should also be available in the PHC. In addition, all the drugs required for the National health programmes and emergency management should be available in adequate quantities so as to ensure completion of treatment by all patients. Adequate quantities of all drugs should be maintained through periodic stock-checking, appropriate record maintenance and inventory methods. Facilities for local purchase of drugs in times of epidemics / outbreaks /emergencies

should be made available. Drugs required for the AYUSH doctor should be available in addition to all other facilities. A model list is annexed.

Transport Facilities

The PHC should have an ambulance for transport of patients. This may be outsourced. Referral Transport Facility: The PHC should have an ambulance for transportation of emergency patients. Referral transport may be outsourced. Transport for Supervisory and other outreach activities: The vehicle can also be outsourced for this purpose.

Laundry and Dietary Facilities (if there are indoor patients) and **Waste management** are other areas included in the standards.:

Quality Assurance

Periodic skill development training of the staff, Standard Treatment Protocols, and Regular monitorings are some of the process requirements for quality assurance. Quality would cover areas of Interaction and Information Exchange and courtesy and respect extended with the client/ patient as well as cleanliness.

Monitoring

This is important to ensure that quality is maintained and also to make changes if necessary.

Internal Mechanism: Record maintenance, checking and supportive supervision

External Mechanism: Monitoring through the PRI / Village Health Committee /Rogi Kalyan Samiti/Jeevan Deep Samiti .A checklist for the same is given in **Annexure A** format for conducting facility survey for the PHCs on Indian Public Health Standards to have baseline information on the gaps and subsequently to monitor the availability of facilities as per IPHS guidelines is given in the annexure to the IPHS documents.

Accountability

To ensure accountability, the **Charter of Patients' Rights** should be made available in each PHC (as per the guidelines given in **Annexure 8 of the IPHS document**). Every PHC should have a **Rogi Kalyan Samiti / Primary Health Centre's Management Committee** for improvement of the management and service provision of the PHC (as per the Guidelines of Government of India). This committee will have the authority to generate its own funds (through users' charges, donation etc.) and utilise the same for service improvement of the PHC. The PRI/Village Health Committee / Rogi Kalyan Samiti will also monitor the functioning of the PHCs.

List of suggested equipments and furniture:

- Normal Delivery Kit
- Equipment for assisted vacuum delivery
- Equipment for assisted forceps delivery
- Standard Surgical Set (for minor procedures like episiotomies stitching)
- Equipment for Manual Vacuum Aspiration
- Equipment for New Born Care and Neonatal Resuscitation
- IUD insertion kit
- Equipment / reagents for essential laboratory investigations
- Refrigerator.
- ILR/Deep Freezer
  Ice box
- Computer with accessories including internet facility
- Baby warmer/incubator.
- Binocular microscope
- Equipments for Eye care and vision testing: Tonometers (Schiotz), direct opthalmoscope, illuminated vision testing drum, trial lens sets with trial frames, snellen and near vision charts, Battery operated torch
- Equipments under various National Programmes
- Radiant warmer for new borne baby
- Baby scale
- Table lamp with 200 watt bulb for new borne baby
- Phototherapy unit
- Self inflating bag and mask-neonatal size
- Laryngoscope and Endotracheal intubation tubes (neonatal)
- Mucus extractor with suction tube and a foot operated suction machine
- Feeding tubes for baby
- Sponge holding forceps - 2
- Valsellum uterine forceps - 2
- Tenaculum uterine forceps – 2
- MVA syringe and cannulae of sizes 4-8 (2 sets; one for back up in case of
  technical problems)
- Kidney tray for emptying contents of MVA syringe
- Trainer for tissues
- Torch without batteries – 2
- Battery dry cells 1.5 volt (large size) – 4
- Bowl for antiseptic solution for soaking cotton swabs
- Tray containing chlorine solution for keeping soiled instruments
- Residual chlorine in drinking water testing kits
- H2S Strip test bottles

Requirements for a fully equipped and operational labour room

A fully equipped and operational labour room must have the following:

1. A labour table
2. Suction machine
3. Facility for Oxygen administration
4. Sterilisation equipment
5. 24-hour running water
6. Electricity supply with back-up facility (generator with POL)
7. Attached toilet facilities
8. An area earmarked for new-born care
9. Emergency drug tray: This must have the following drugs
   - Inj. Oxytocin
   - Inj. Diazepam
   - Tab. Nifedepine
   - Magnesium sulphate
   - Inj. Lignocaine hydrochloride
   - Inj. Methyl ergometrine maleate
   - Sterilised cotton and gauze
10. Delivery kits, including those for normal delivery and assisted deliveries.

PRIVACY of a woman in labour should be ensured as a quality assurance issue.

List of equipment for Pap smear

1. Cusco's vaginal speculum (each of small, medium and large size)
2. Sim's vaginal speculum – single & double ended - (each of small, medium and large size)
3. Anterior Vaginal wall retractor
4. Sterile Gloves
5. Sterilised cotton swabs and swab sticks in a jar with lid
6. Kidney tray for keeping used instruments
7. Bowl for antiseptic solution
8. Antiseptic solution: Chlorhexidine 1% or Cetrimide 2% (if povidone iodine solution is available, it is preferable to use that)

9. Chittle forceps
10. Proper light source / torch
11. For vaginal and Pap Smears:
    - Clean slides with cover slips
    - Cotton swab sticks
    - KOH solution in bottle with dropper
    - Saline in bottle with dropper
    - Ayre's spatula
    - Fixing solution / hair spray

Requirements of the laboratory Reagents

1. For Cyan meth - haemoglobin method for Hb estimation
2. Uristix for urine albumin and sugar analysis
3. ABO & Rh antibodies
4. KOH solution for Whiff test
5. Gram's iodine
6. Crystal Violet stain
7. Acetone-Ethanol decolourising solution.
8. Safranine stain
9. PH test strips
10. RPR test kits for syphilis

Glassware and other equipment

1. Colorimeter for Hb estimation
2. Test tubes
3. Pipettes
4. Glass rods
5. Glass slides
6. Cover slips
7. Light Microscope

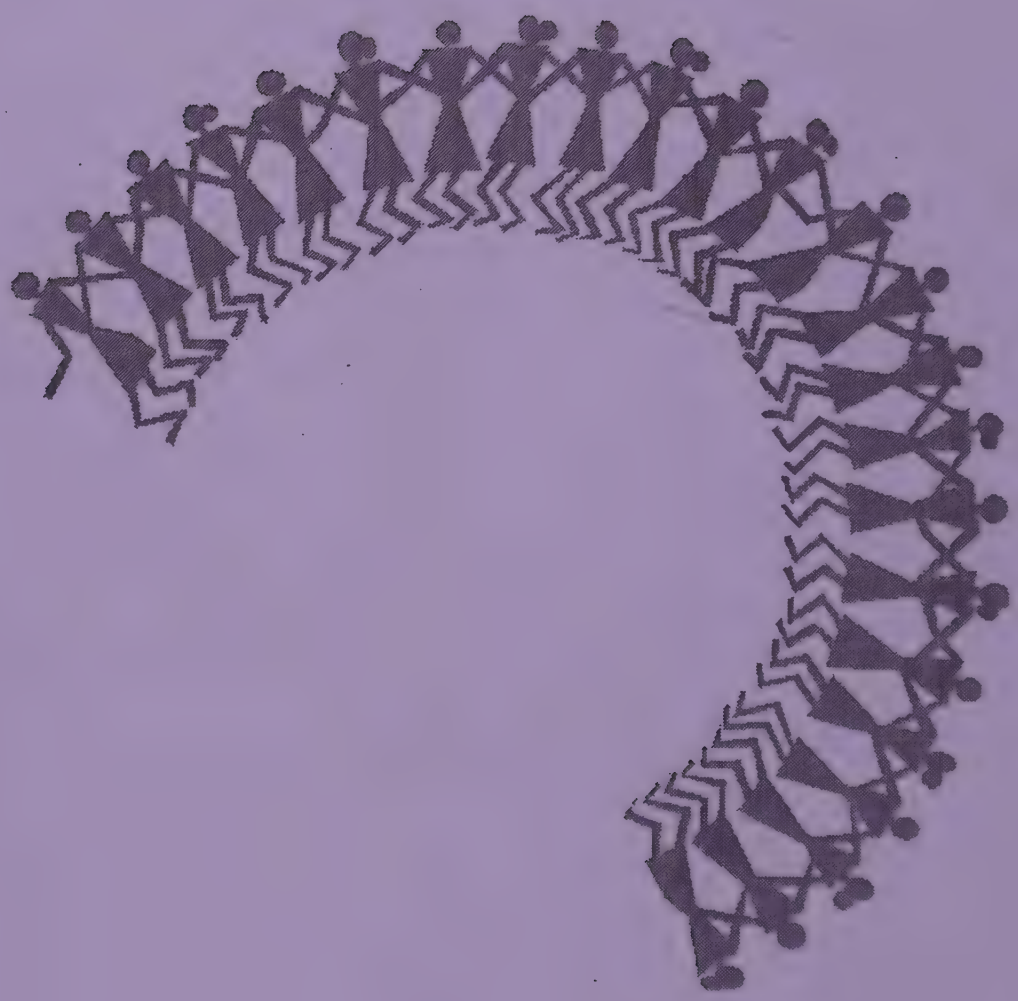
List of Furniture (including surgical) at PHC

Examination table - 3
Writing tables with table sheets - 5
Plastic chairs (for in-patients' attendants) - 6
Armless chairs - 8
Full size steel almirah - 4
Labour table - 1
OT table - 1
Arm board for adult and child - 4
Wheel chair - 1
Stretcher on trolley - 1
Instrument trolley - 2
Wooden screen - 1
Foot step - 5
Coat rack - 2
Bed side table - 6
Bed stead iron (for in-patients) - 6
Baby cot - 1
Stool - 6
Medicine chest - 1
Lamp - 3
Shadowless lamp light (for OT and Labour room) - 2
Side Wooden racks - 4
Fans - 6
Tube light - 8
Basin - 2
Basin stand - 2

Sundry Articles including Linen:

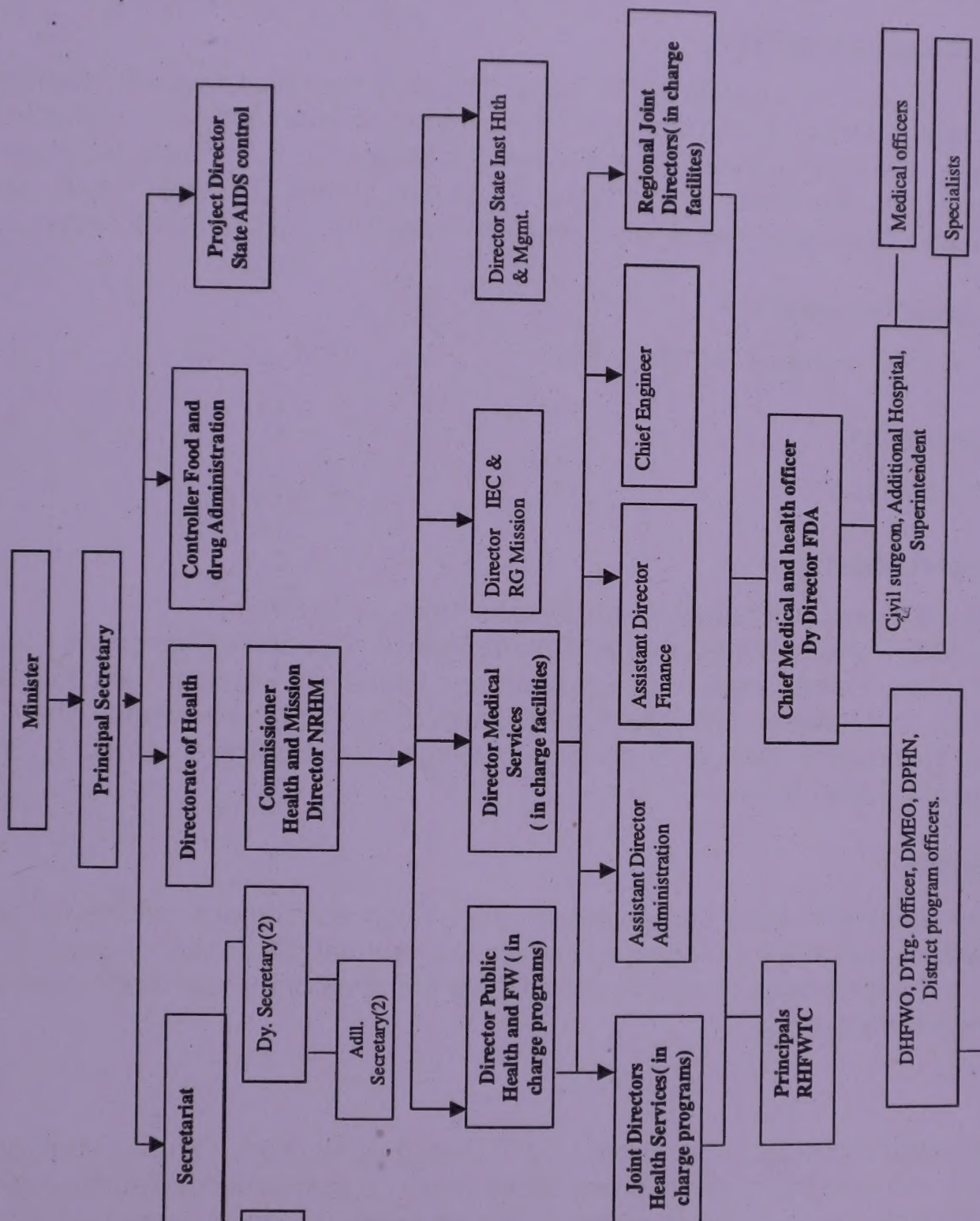
Buckets - 4
Mugs - 4
LPG stove - 1
LPG cylinder - 2
Sauce pan with lid - 2
Water receptacle - 2
Rubber/plastic shutting - 2 meters
Drum with tap for storing water - 2
I V stand - 4
Mattress for beds - 6
Foam Mattress for OT table - 1
Foam Mattress for labour table - 1
Macintosh for labour and OT table - 4 metres
Kelly's pad for labour and OT table - 2 sets
Bed sheets - 6
Pillows with covers - 8
Blankets - 6
Baby blankets - 2
Towels - 6
Curtains with rods - 20 metres

NOTES



Annexure 2

Example of the Organisational and Management Structure of a Department of Public Health & Family Welfare



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